POVERTY, COMMUNITY AND HEALTH:
Social networks as mediators between poverty and well being

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ABSTRACT

This thesis argues that social networks are key mediators between the harsh circumstances of people's lives and their lived experience and perceptions of health and well being. The thesis offers a critical review of the literature on health inequalities and social networks and health and from this identifies key concepts which serve as analytical/heuristic tools in approaching a study of the dynamics between poverty, community and health in the Lea Valley area of London. The complexities of the relationship between these various aspects of life are currently under researched in the literature.

Both quantitative and qualitative methods are utilised. A statistical overview of the Lea Valley was undertaken and confirmed relationships between lower social class, poverty and deprivation (on a comprehensive range of measures) and poor health for the region. The evidence is considered in relation to current conceptual approaches to poverty.

Two deprived areas are chosen as exemplary case studies and through detailed analysis of interview data the relationship between neighbourhood, social networks and the experience of health and well being is illustrated. Different social network formations were found to mediate poverty and health in different ways. Local patterns of social networks were influenced by local structural and historical features, by facilities and opportunities, including opportunities for positive neighbouring, for forming friendship networks, and for participation in local life as well as for casual interaction. Individuals' social networks were influenced by characteristics of their neighbourhood, by their perceptions of their community as well as by their experience of work, their values, and attitudes to others.

It is suggested that the range of membership groups in an individual's network has implications for the mechanisms involved in the relationship between networks and health. Health promoting functions of networks and health protecting or damaging attributes and attitudes were found to be closely related to the type of network identified. Different network models also helped people to cope with poverty and life's problems in different ways. It is concluded that social networks, attitudes and values, coping resources and health and well being are closely linked. A conception of social cohesion at the neighbourhood level is offered, based on interaction, strong community perceptions, solidarity, trust, inclusion and tolerance, with adequate distribution of resources and availability of work as preconditions.

CONTENTS

1. SETTING THE CONTEXT

The framework of the study

This thesis looks at the dynamic relationship between poor people, poor places and poor health, and considers the role of social networks in the processes involved.

It focuses on the individual, the pattern of social networks in which the individual is located, the community or neighbourhood in which she or he lives and the wider structural factors which affect all three. The research is underpinned by the solid and growing body of evidence on social inequalities in health.

It has three aims:

1. To better understand the mechanisms and social processes involved in
   a) the relationship between poverty and health, and
   b) the protective influence of social networks on health

2. To identify characteristics of "communities" which are beneficial to the health and well being of people living in today's very deprived areas

3. To consider concepts of social cohesion, exclusion and inclusion, especially their utility as explanatory concepts in the dynamics between poverty, community and health.

The background to the thesis and its contribution to the literature

A substantial body of literature exists on social inequalities in health. As the Kings Fund put it: "People who live in the most disadvantaged circumstances have more illness, disability and shorter lives than those who are most affluent", (Benzeval et al, 1995, p.xvii). Indeed the 'multiply deprived' have been shown to be almost 10 times more likely to consider themselves as having poor health than the least deprived (Benzeval, Judge and Solomon, 1992). This thesis is a timely and unique contribution to work on health inequalities.

It is *timely* on four counts. First, a paradigm shift means that the public health policy context now openly acknowledges that social and economic factors influence health and that they structure inequalities. A desire to tackle these inequalities is evident in Government policy documents. Secondly, both policy debates and academic discourse reflect a changing view of poverty, one which is concerned with factors in addition to a focus on low income, and looks for example, at

'social exclusion'. Thirdly, there is currently a strong Governmental interest in communities and neighbourhoods. These are seen as central ingredients of Prime Minister Blair's 'Third Way', with its emphasis on co-operative self help.[1] Fourthly, official reports stress the need to investigate causal processes involved in health determinants.[2]

When the Black report on health inequalities (Black, 1980) appeared in 1980 it received a hostile reaction from the Government who attempted to suppress its findings. Similarly, the 1986 Decennial Supplement on class related mortality differentials, which showed an increase in inequalities since the previous official figures, was not published in the form of a report but simply as somewhat inaccessible statistics on fiche. The middle years of the decade were generally characterised by some suppression of information. The publication of poverty statistics for example was delayed until the Parliamentary recess.[3] The latest Decennial Supplement on Health Inequalities (ONS,1997), which again points to widening differentials, has this time been published as a substantial report. It was born into a political climate committed to tackling health inequalities, and the report is, in itself, perhaps a reflection of the Blair Government's commitment to openness in government.

The political climate in relation to health inequalities did begin to change however under the John Major administration. Although successive Conservative Governments, uneasy with the word "inequality", refused to acknowledge the findings of reports such as the Black Report on inequalities in health between social classes, (labelling differences as "variations" not inequalities) a Department of Health Report, *Variations in Health* recognised health differences between population groups.[4] *Variations in Health* describes the situation succinctly, and recognises its complexity: "For several decades now it has been well documented that across the developed world, there are variations in the extent of sickness and premature death between different groups within populations. Some groups can expect to enjoy substantially better health and longer lives

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1 For commentary on the Third Way see for example McSmith, A (1998) "Third Way? Which way?", *Observer*, 10th May.

2 See for example Department of Health (1995) *Variations in Health: what can the Department of Health and the NHS do?* Report by the Variations Sub-Group of the Chief Medical Officer's Health of the Nation Working Group, October.

3 I had direct working experience of the policy climate at the time.

4 Its predecessor, *Health of the Nation* (Department of Health 1992) was criticised for insufficient attention paid to social inequalities in health.

than others. These variations in health status are associated with a range of often interacting factors: geography, socio-economic status, gender, environment, ethnicity, culture and lifestyle. Variations persist even as health improves overall across the population" (Department of Health, October 1995, p.5).

A major ESRC research programme is currently addressing the question why there are persistent and widening socio-economic differences in health in the United Kingdom, (Graham, 1997). Graham, the Programme Director explains that an important catalyst for the change in policy climate involving a willingness to engage with class differences in health has been the introduction of a strategic approach to health policy. *Health of the Nation* (Department of Health, 1992) strategies involve precise targets and fixed timescales. Key areas for attention include coronary heart disease, stroke and lung cancer, all of which are characterised by class gradients in mortality and in health related behaviours, including smoking and diet, (Graham,1997).

In 1995, Sir Donald Acheson, Chief Medical Officer of Health until 1991, insisted that we needed a national commitment to tackle social inequalities in health coupled with a sense of urgency at the top, (Acheson, Sir D (1995) pp. x-xi). The proposals put forward in the recently published consultation document, *Our Healthier Nation* (Secretary of State for Health, 1998), reflect the present Government's key aims in public health. They are to improve the health of the population as a whole and to improve the health of the worst off and narrow the health gap. Part of the strategy has been to set up Health Action Zones in England to target health inequalities. One of the Health Authority areas examined in the local study in this thesis, East London City and Hackney, has been granted Health Action Zone status. Health Authorities will be expected to work in partnership with local authorities as well as community groups, the voluntary sector and local businesses to improve health care and health outcomes. The Government itself has demonstrated its commitment by appointing a Minister for Public Health for the first time, and by setting up a dedicated Cabinet Committee of Ministers from twelve different departments to drive policy across Government (Secretary of State for Health, 1998, p.31)

Our Healthier Nation links poor health to social exclusion, arguing, for example, that when poor housing, unemployment or low pay, fear of crime and isolation are combined, then people's health can suffer disproportionately. Part of the solution, to the Government, lies in the 'Middle Way' approach: "The best way to make a start on helping them live healthier lives is to provide help and support to enable them to participate in society, and to help them improve their own economic and

social circumstances. That will help to improve their health" (Secretary of State for Health, 1998, p.17). However, an inquiry led by Sir Donald Acheson will be reporting in the Summer of 1998 on ways of tackling health inequalities. It will be interesting to note to what extent the report will be congruent with key features of *Our Healthier Nation*, that is, those which focus on a contract between individuals, communities and the Government, or whether the balance will be weighted more towards what the Government can do in terms of re-distribution.

The thesis itself makes a *unique* contribution to the literature. It explores complexity; contributes to the debate about the independent role of place, and adds to the literature on social networks and health by exploring process, by identifying how and under what circumstances social networks can be protective to health.

A wide array of influences are now recognised as influencing health, and a good deal of excellent work is being undertaken which looks at the separate influences of various factors.[5] The latest Decennial Supplement on health inequalities recognises that different layers of influence interact in complex relationships. The thesis helps to illustrate this complexity. It pulls together diverse strands of poverty and deprivation, neighbourhood factors and processes involved in health and well being. In this way, the thesis offers a contribution to the literature on social exclusion, a concept which embraces a view of poverty concerned with multiple aspects of deprivation, with the role of neighbourhood and with process.[6] It also identifies factors which can aid social *inclusion*.

The thesis contributes to the debate in the literature on the independent role of place in health inequalities. It does so by: a) contributing to the evidence on London's anomalous position in terms of health and deprivation and shows that worsening health indicators in East London are located within a context of widespread poverty and deprivation and growing long term unemployment; b) by considering the importance of deprivation indicators selected and the spatial scale adopted for analysis when measuring poverty, it raises questions concerning the significance of 'concentrated poverty' to health effects; and c) by exploring neighbourhood influences on the formation of health protecting social networks. Contributing to the current debate in the health

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5 See eg, ONS 1997; Pantazis and Gordon, 1997; Graham, 1998; Blane, Bruner and Wilkinson 1996.

6 See eg, Oppenheim, C (1998) "Changing the storyline", *Guardian*; Society, 1st April, p. 6.; Hills,J (1997) "A case for investigation", LSE Magazine,; Winter, pp.7-9

literature about whether a 'miasma effect' can be identified in poor areas,[7] the thesis rejects notions of contagion evident in discourse on 'concentrated poverty' and instead focuses on the influence of neighbourhood factors in fostering health promoting social networks.

Although the literature has clearly demonstrated that social networks are important for health and well being, there is less known about the mechanisms involved. The thesis makes an important contribution to our knowledge of what it is about wider social networks which are health protecting or promoting for the individual concerned, and why social networks are particularly important for the poor and deprived. Rather than treating social networks as uni-linear phenomena it unpacks the various elements of a network- the characteristics of the people in the network, the structure of the network, the functions they provide, identifies 'models' of networks and demonstrates that different network patterns are beneficial or damaging to health and well being in different ways.

The thesis makes a major contribution to our knowledge of the processes involved in patterns of health and illness. In particular, it demonstrates that social networks mediate an individual's poverty and ill health through mechanisms of values, attitudes and behaviours, as well as coping, support and resources, and that social networks mediate place and health and well being through opportunities to form health enhancing social networks. Material factors are not neglected however. Although social networks are identified as key mediators between poverty and health and well being, there is much evidence in the thesis to confirm that even if networks can ameliorate the harsher health effects of poverty and deprivation, they are, nevertheless, no substitute for a more equitable distribution of resources..

Wlkinson, (Wilkinson, 1996), in an important contribution, takes a broad view of health determinants, and links income inequality with a lack of social cohesion and reduced health chances. My thesis moves on from the Wilkinson approach by looking carefully at the processes involved in these relationships, and by focusing on both people and places. It suggests a concept of social cohesion which is relevant to late 20th Century urban neighbourhoods and which is likely to be of benefit to health and well being.

Finally, the thesis is pertinent to the on-going academic and policy debate concerning the elevation of equality of opportunity versus equality of outcome as crucial goals. It illustrates that both

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7 See eg, Sloggett and Joshi, 1994; Robert, 1998.

inequalities in the distribution of resources *and* inequalities in opportunities to lead healthy lives contribute to health inequalities.

The thesis builds on my Master's Dissertation, which, in a review of the literature (Cattell, 1992) compared two of the major - and generally quite distinct - approaches to health determinants , a) the effect of socioeconomic position in structuring health chances, and b) the influence on health of the patterns and extent of an individual's social networks and community ties. I discussed them within the context of contemporary discourse and evidence on poverty, and, to a lesser extent, community. Overall, the dissertation concluded that: 1)The traditional dichotomy between class and community in relation to health was unnecessary, 2) power, though neglected in the bulk of the studies examined, could be a crucial explanatory factor in both approaches to health; 3) the importance of social as opposed to material deprivation in explaining class related structures of health inequalities had been neglected, particularly in relation to physical health; 4) social and economic change in the 1980s has had a disproportionate effect on some poor groups in British society, and that various forms of social deprivation we associate with change, including perceptions and experience of powerlessness could be expected to take their effect on health and 5) policies of integration, particularly initiatives which encouraged community participation, could probably do much to benefit the health of the poor.

THE CURRENT CONTEXT

How do these ideas and commentary on the poverty and community literature of the 1980s outlined in the dissertation stand up in the light of contemporary debate and evidence on health, on poverty issues, and community issues? Are there any noticeable shifts in the ideological climate underpinning debate?

Health

The results of the second part of a major investigation into the health of Civil Servants *The Whitehall II Study* indicate that my suggestions on the likely importance of power and control as causative factors for patterns of health inequalities in a hierarchical situation, reflected current directions of thinking. A strong inverse relation between grade of employment and sickness absence was evident for both men and women. Several risk factors were identified, but differences between rates of sickness absence for men and women who reported low control, variety, and use of skills, were particularly striking, (North et al, 1993).

The Whitehall II study suggests that although power and control are clearly important health

determinants - at least in the work situation, it would be inappropriate to consider control in isolation from other factors associated with ill health. "Differences between subjects in health, health related behaviours, psycho-social aspects of the work environment, and social circumstances outside work accounted for about a third of the threefold to sixfold differences in sickness absences by grade. This still leaves a large proportion of the variation unexplaine," (North et al, 1993 p 364). A recent contribution by Wilkinson links good health to self esteem and position in the social hierarchy. He argues that 'Instead of health being affected directly by material circumstances, the social implications of your position in society is the key' (Wilkinson, 1997). For evidence on the mechanisms involved, he refers , as well as to *Whitehall II*, to studies of animals whose social life operates in some form of hierarchy. Low status baboons for example, with little power, have been found to suffer the health effects of chronic stress, (Wilkinson, 1996). As I argued in my dissertation however, health inequalities are not likely to be a product simply of one or another - material circumstances or social position. The most important social position is social class, and class *is* a hierarchical system of inequalities, material resources included. There are other dimensions also.

Wilkinson's central argument - a development of his earlier work which is discussed later in the literature review in this thesis - is that the healthiest societies - in terms of average health standards - in the developed world are not the richest ones, but those with the most egalitarian income distribution (Wilkinson, 1996 p. 78). His explanations are two-fold. The first is that perceptions of income inequality are detrimental to health. The second, that healthy, egalitarian societies are more socially cohesive. They have a stronger community life and suffer fewer of the corrosive effects of inequality. Referring to published studies he argues that social cohesion is the primary factor associated with the quality of life and good health. For Wilkinson, societies which are egalitarian and healthy are also markedly more socially cohesive than others. In such societies people are *connected to public life through a variety of organisations and activities*. In inegalitarian societies, as well as experiencing higher death rates from most causes, such societies also show higher rates of alcohol related deaths, accidents, homicide, crime, violence and drug use, (Wilkinson, 1996).

The argument that "social cohesion" (as Wilkinson defines it, that is, people are connected to public life through a variety of organisations and activities) is beneficial to health is really very similar to the solid and growing body of research on social networks, community participation and health of the kind reviewed later in this thesis. It also links to my suggestions, outlined above, on the likely benefits to health of participation in community initiatives. A difference concerns the

linkage with crime, a process which *Faith in the City*, amongst others, have referred to as one of 'social disintegration.' [8] A difficulty perhaps with the Wilkinson analysis is that problems concerned with place, with the scale of analysis, are not made explicit. An unequal 'society' or a socially cohesive society refers variously to countries, American states, and towns. The difference that "place" can make to health is one of the issues explored in this thesis.

The salience of features associated with locality to health, that is those over and above the characteristics of resident populations, have been coming to the fore recently in area studies on deprivation and health, and are discussed later. The emphasis on locality is not of course new. Engels identified differences in life expectancy between poor and better off English towns and streets within towns in the earlier part of the nineteenth century (Engels, 1844). An important and authoritative study which demonstrated the links between *social cohesion* of a locality and health, was that carried out over several decades in Roseto, a small American town. Starting from the premise that previous explanations for the unequal distribution of Coronary Heart Disease have largely focused on the individual as the unit of analysis, Lasker *et al* argue that a shift in focus to community level characteristics may aid in understanding the distribution of and changes in mortality, (Lasker et al,1994).

The "social cohesion" of the Roseto studies clearly referred to family (including extended family) ties and support, to community interaction and support and participation in local organisations. (Lasker et al 1994; Egolf et al, 1992). In other words, to the patterns and nature of social networks of individuals and the community as a whole. Values - the Catholic religion, co-operation, lack of ostentation were part of the picture of community life. Culture, social organisation and participation appear interdependent in Roseto.

Many of the features characteristic of Roseto are ones which we associated with the "traditional community" in this country, including the traditional working class community. The classic British tradition of community studies described and analysed the features of traditional working class communities of the middle of the 20th century. Frankenberg's 'Glynceiriog' for example, a Welsh village, was well supplied with pubs, chapels and shops. It was a working class community and

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[8] There is a extensive criminology literature on this topic. Hirschfield and Bowers, for example, compared areas with high levels of deprivation and demonstrated that 'social cohesion' is linked to lower levels of crime. Lack of social cohesion was measured by demographic factors such as lone parent households, ethnic and social heterogeneity, as well as 'command and control' data, ie, calls for police service (Hirschfield and Bowers, 1997).

strongly egalitarian in outlook (Frankenberg,1966). The Bethnal Green of Young and Willmott was in the 1950s (Young and Willmott 1957), similarly a one class borough, a part of London now always to be identified for its patterns of close knit networks of kin and for strong community loyalties.

The point is, there have been many changes, some of which were outlined earlier, operating to influence the cohesion of working class communities, and change can, in itself, (as it did in Roseto in the 1960s) have detrimental effects on health.[9] Changes in Roseto, unlike the changes evident in British inner city districts, were not related to increasing poverty and unemployment but to changes in its social organisation, to a change of culture towards Americanisation for example, to greater occupational attainment, to less intermarriage, and to reduced participation in local activities and organisations, particularly in the case of men. Increasing poverty does not seem to be the only feature of change which can impact negatively on health.

The Roseto community was - when its mortality rates were good - a homogenous, stable unchanging society. We cannot expect to replicate those same conditions now. Wilkinson's view of social cohesion appears to be a static one.

We now need to identify contemporary kinds of local conditions which make for 'social cohesion' and which are likely to benefit health in today's changed circumstances. There are many towns, districts or smaller areas in Britain characterised by high unemployment, urban decline, population heterogeneity, high turnover of population, despair, lack of hope, and rising crime. MacGregor and Lipow describe the undermining of the traditional working class culture of manufacturing - largely a male world in which young men were socialized and disciplined through the apprentice system - and ask, what will take its place? The traditional institutions of the pub, the workplace, and shared involvement in sport, they argue for example, cannot easily be recreated . But, they suggest, there is a need for some alternative forms of informal social control and socialization - such as youth workers, teachers, outreach community workers - the very people and activities which have, however, been cut in the last decade due to cutbacks in public expenditure (MacGregor and Lipow, 1995,p16). The critical importance of these issues became apparent during later fieldwork.

At the neighbourhood level, conditions that make for social cohesion might include those which foster the maintenance and development of local forms of social interaction including

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[9] See, for example, Brenner (1979); Cassell (1976)

neighbourliness. Participation in community initiatives, as suggested earlier, may be important here. There has been a shift in emphasis in contemporary British accounts of community, to incorporate not only kinship and other networks as important sources of support and practical help but towards a more political use of the term. The word community now, argues Willmott, is used in discussions of community initiatives, that is community-based activities which aim to improve local services , increase participation in decision making. and foster shared interests and identities.[10] Participation in a range of informal social organisations, such as churches and mosques, clubs, self help groups, co-operative businesses and others, are likely to be highly important too. Both kinds of participation - formal and informal- have been shown to be beneficial for health.

A paper I presented to the BSA Annual Conference in 1995 attempted to pull some of the issues on community, participation and social networks together. A conception of a'positive community' for positive health was suggested, characterised by flexible social networks, sociability, co-operation, tolerance, solidarity, utopian dreams and supportive and democratic structures. Social cohesion , as it was described here, referred to social solidarity, and related to communities where working class people were not divided, and recognised shared interests with unlike groups, (Cattell,1995) .

The concept of social cohesion is, of course, wider and deeper than this. It constitutes a re-emergence of concerns which underpinned Titmuss and Marshall's views on social policy, in particular the desire for social integration, itself a reflection of Durkheim. Social cohesion was a concept applied to a whole society, and not simply to geographical areas within it. Titmuss believed that social, economic and fiscal policies had a key role to play in the realisation of a socially cohesive undivided society, (Titmuss, 1987). Citizenship, for Marshall, (1950) involves a process of equalisation of civil, political, and social rights. It also implies the right to live the life of a civilised human being according to the standards prevailing in society. Contemporary variants of the concern with social cohesion include a focus on its lack, and on notions of social exclusion and inclusion, concentrated poverty, insecurity, crime and a growing "underclass". Some of these are

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[10] There is an extensive literature on community development from the 1970s onwards which is concerned with these issues, and especially with participation as a means of empowerment. See for example Barr,A "Reflections on the Enigma of Community Empowerment", Paper presented to Conference on *Rivers of Blood: Cities in Crisis,* April 3rd and 4th, 1995, Durham University; Broadley,M and Hedley,R (1983) *Working partnerships: Community Development in Local_ Authorities,* Bedford Square Press for the National Coalition of Neighbourhoods; Croft,S and Beresford, P (1992) "The politics of Participation", *Critical Social Policy*; Autumn, pp.20-44.

examined later in this thesis.

Redistribution continues to be a key issue, just as relevant now as it was when Titmuss was writing. Wilkinson's focus on income inequalities as a contributory factor for lack of social cohesion (as well as health inequalities) is important. Central Government policies - particularly fiscal - will play a role, and so too will a range of policies implemented by local as well as central government. MacGregor and Lipow stress the importance of anti-poverty innovations which aim to increase integration and inclusion, reduce inequalities and polarisation, and effect a shift in resources from the more privileged to the less privileged, (MacGregor and Lipow, 1995).

Poverty and Social Inequalities in Health in the 1990s

Official statistics have indicated dramatic changes in income distribution since 1979. Analyses by the Joseph Rowntree Foundation inquiry into Income and Wealth indicate that poverty has grown and deepened and inequalities widened. Not only the very poorest suffered. Only the top three-tenths of the population ranked by income achieved above average income growth between 1979 and 1991, and only the top fifth had a larger share of total income in 1990/1 than they had in 1981(Joseph Rowntree Foundation 1994; Goodman and Webb 1994; Jenkins 1994; *Social Trends*, 1994). Growth in inequality has been unprecended in recent years. The gap between the rich and middle income earners has grown, as well as the gap between the middle groups and the poorest (Goodman et al, 1997).

It would not be unreasonable to suppose that growing inequalities in income during the late 1980s/ early 1990s period would be reflected in widening health inequalities. Research and official statistics on both social groups and places suggests this to have been the case. A long awaited report on the decennial supplement on class and mortality produced by the Government Statistical Service has just been published. Preliminary findings had suggested that class related health inequalities continue in much the same pattern and are widening, at least for males in unskilled groups in relation to other class groupings, (Drever ,1996). The new report found that between 1982-86 and 1987-91, life expectancy for males in social classes IV and V fell from 69.8 years to 69.7 years. An improvement in the infant mortality rate and for school aged girls has prevented the life expectancy rates for women in social classes IV and V from falling (ONS, 1997). Estimates based on alternative social indicators to social class indicate increasing mortality differentials by housing tenure and car access also, (ONS, 1997). In the Northern region, a clear worsening of mortality relative to the national level in the poorest fifth of wards was accompanied by little

relative change in the second and middle fifths and an improvement only in the most affluent 40% of wards, (Phillimore, 1994). Nationally, the mortality differences between areas has grown since the 1980s to its highest recorded level. People under 65 living in the worst tenth of areas were almost twice as likely to die in 1990-92 than people living in the tenth of areas with the lowest mortality rates, (Dorling, 1997).

It might, however, be naive to suggest that there is commonly some immediate and rapid response to reduced income or other deprivation factors which result in premature death, though studies on both the effects of unemployment and changes in income (reviewed later) confirm the importance of these factors to health and health related behaviours on a range of measures, subsequent mortality included.[11] Davey Smith et al have demonstrated however that socio-economic position over the lifetime affects health and risk of premature death, and argue that studies with data on deprivation at only one stage of life are inadequate for fully understanding the contribution of socio-economic factors to health and mortality risk. The Department of Health's *Variations in Health* has directed attention to the importance of accumulated socially adverse exposures over a lifetime, (Davey Smith_et al, 1997).

One of the aspects of poverty (and health) taken up later in this thesis concerns spatial issues. Though some researchers are wary of identifying poverty too closely with geographic areas, (see Chapter 2), recent research on poverty has identified a 'concentrated poverty' effect, where certain areas - usually the most unpopular housing estates - are becoming increasingly the domain of the very poor.. "Wider social and economic pressures [in the 1980s and early 1990s] pushed the most disadvantaged - often unemployed, lone parents, people from ethnic minority groups - to the most marginal areas". (Power and Tunstall, 1995, p.6) .Whereas the "Right to Buy" had altered tenure patterns in the country as a whole, in these more unpopular estates, very little change had taken place. Power and Tunstall add that "The fear of social breakdown resulting from the increasing concentration of needy and vulnerable households was so acute that special localised measures to reinforce community stability were constantly necessary" (Power and Tunstall, 1995,p.4) .

A recent JRF report indicates that newcomers moving into disadvantaged estates are even more disadvantaged than existing tenants. They include lone parents and unemployed people, (Burrows,1997). Research also indicates however, that the growth in poverty and unemployment is not restricted to certain areas, or to certain particularly vulnerable groups. Many of those moving

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[11] See for example Bartley, (1994).

into the most unpopular housing estates were former home owners who have had their property repossessed. Middle class people and middle class areas are affected too. There is, as Will Hutton has put it "Angst in Acacia Avenue" as economic insecurity spreads, (Hutton, 1994) Mortgage debt, for example, is affecting increasing numbers of the middle classes, (Ford, 1996).

Social Cohesion and Communitarianism: the 1990s Policy Debates

The ideas underpinning this thesis thus have some resonance with current research and thinking on health inequalities. Are they congruent with aspects of the current ideological and political climate? Is the current climate relevant to investigations of poverty, community and health?

The effects of unbridled individualism have continued into the 1990s. Academics, journalists and politicians now focus , as well as on social exclusion, on inclusion too. They ask - how do you bring the people back in?[12] It is argued that economic and social policy must be taken together (as indeed they were in 1945), and that redistribution is the crucial issue (MacGregor and Lipow 1995). Hutton recognises a general concern about the direction of both the economy and society, and a hunger for a different way forward, (Hutton, 1995). For Hutton the way forward - or at least part of the way - lies in stake holding.

For Hutton, the unifying idea of stake holding is inclusion: the individual is a member, a citizen and a potential partner. In the workplace, employees can be encouraged to have a stake in the firm. In welfare, inclusion implies a universal welfare state, financed by progressive taxation, in which the opted out middle class are reincorporated. Political inclusion includes decentralisation of government along with more accountability. But, argues Hutton, the ultimate stake for most adults is a job. Stake holder institutions must be buttressed by full employment policies (Hutton, 1996). Inclusion/stake holding here are really very similar to Marshall's concept of citizenship mentioned earlier.

For the present Prime Minister, economic inclusion and social cohesion are linked, they are the basis for a fair and strong society. Blair wants to build a cohesive, one nation society by tackling long term and structural unemployment, reforming the welfare state, and encouraging the move from benefits to work. In this way, he believes, poverty will be more effectively tackled, as will the "...moral and economic evil...[of a development of] an underclass of people,excluded from

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[12] See for example Susanne MacGregor and Arthur Lipow (1995) "Bringing the people back in: economy and society in London and New York" in MacGregor and Lipow, The Other City,New Jersey, Humaniteis Press, pp. 1-27.

society's mainstream," (Blair, 1996,p.116) Social cohesion here, in the Blair vision, is the opposite to social exclusion, it is social *in*clusion. The one nation rhetoric may be harking to the solidarity of the 1940s, but the analogy strikes a discord. For Disraeli, who coined the phrase, 'One nation Conservatism' involved bringing the two nations - rich and poor- closer together, but not too close. In Disraeli's vision, rich and poor would be more tolerant and understanding of each other, but the rich were to remain rich, and the poor to remain poor and suitably deferential, (Disraeli, 1845).

There is perhaps too little in Blair's ideology of the form of social cohesion and social integration espoused by Titmuss, of the redistribution through fiscal, as well as social and economic polices which he advocated. I argued in my dissertation, that it is mainly through redistribution that we are likely to witness dramatic improvements in inequalities in health, (Cattell 1992 p.41). The point has relevance for the current ideological argument on what equality should mean to the Labour Party. Roy Hattersley continues to argue for the traditional elevation of equality of outcome as a principal goal. For Gordon Brown, (Chancellor of the Exchequer) it is equality of opportunity which is the way forward.[13]

Fuelled by evidence on rising crime, increased drug taking and disorderly behaviour, the interest in stake holding and social cohesion has grown alongside a concern with 'community'. A development of current political and sociological interest in community is evident in 'communitarianism'. The communitarian critique of political philosophers is an attack on Liberalism. It focuses particularly on the autonomous individual of Liberal social theory. Prominent communitarians - Sandel, MacIntyre, Waltzer, Taylor and Etzioni, argue that approaches which stress the importance of the individual, and individual freedom (including Hattersley) are wrong: people are not atomised individuals, but essentially social beings, rooted in families and communities. They argue that both dominant ideological political paradigms of the previous quarter century have failed. Neither the welfare state model of the 1960s and 1970s (in America) nor the free market Conservatism of the 1980s has been able to reverse the social fragmentation engulfing America in crime, drug abuse and moral irresponsibility. Both models had failed to place the encouragement of social responsibility and the common good at the centre of their concerns, (Sayers, 1995, pp.2-5; Anderson and Davey, 1995, pp.18-20) .

Waltzer argues that we need to overcome the alienation of modern liberal society, and recognise and recover our sense of the understandings and bonds we share as members of a common

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13 See, for example, Brown,G (1996)"In the real world",*Guardian;* 2nd. August, p.13.

community. But asks Sayers, whose values are we talking about? (Sayers, 1995, p.3) Should we, in any case, be attempting to curb individual autonomy ? We need to create new forms of common life, he argues, which accept individual autonomy and differences of values as real features of the modern world.

Communitarian ideas have been eagerly seized by politicians of varying political persuasions. They appear to dovetail with Tony Blair's ethical socialism for example, (Anderson and Davey, 1995). It was Rawls' conception of social justice which influenced the Labour Party in the 1970s and 1980s, it was justice as fairness, reflected in Roy Hattersley's *Choose Freedom,* and the 1994 Borrie Commission on Social Justice. This paradigm, so it has been argued, has almost been eclipsed by communitariansm, (Anderson and Davey, 1995).

According to the American sociologist Etzioni, communitarianism concerns the need to create a new moral, social and public order based on restored communities, without allowing puritanism or oppression. He believes that we must balance our passion for individualism with a new sense of social responsibility. He defines communitarianism as a social movement aiming at shoring up the moral, social, and political environment (Etzioni, 1993, p.245). For Etzioni, the balance of rights and duties has swung too far in favour of rights. He advocates a number of measures to put the balance right: parents should be actively discouraged from splitting up; single women should be discouraged from having childre; there should be economic incentives to make it easier for one parent to stay at home to look after children;and the state should provide generous maternity leave. To shore up communities, he stresses that schools must be given more respect, and spaces made more community friendly. In addition,"all of us need to invest more of ourselves in one another" ,(Etzioni, 1993, p.248). In this way, he believes the social webs in neighbourhoods, at work, in clubs and associations will be helped to help us maintain a civic social and moral order.

Communitarian ideas have been criticised by feminists for reasserting the norm of the heterosexual two-parent family, by others for harbouring a nostalgic or territory based view of community, and for their disregard of conflict, (Anderson and Davey, 1995; Bell, 1993). There is also an authoritarian tinge to them. However, social entrepreneurs traditionally associated with the centre left may also have been influenced by aspects of communitarian ideas, though mixed with older forms of socialism including Owenism. Michael Young has argued recently that in the 20th Century equality has triumphed over fraternity, at least in public housing. Tenants for new housing have been chosen according to their needs, but this has been at great cost to fraternity. Families on the waiting list have usually been rehoused on their own, rather than with people with whom they

have ties of kinship, friendship and obligation. A new small scale Housing Association in inner city Bradford takes an entirely different approach. Tenants will be drawn from extended families in Bradford who want to stay together, and from neighbourly areas where people want to move together. What is really different however, is that residents will be expected to commit themselves to the community, and offer their services. The Housing Association will create a small labour force drawn from residents to maintain the properties and facilities. They will also secure contracts from the Local Authority for the care of elderly and disabled, and to run a nursery, all of which will employ local residents. "Meeting the urgent needs for housing, and rebuilding communities can happen at the same time. Equality and fraternity ... were never meant to be in conflict," (Young, 1996,p.6).

Questions to Be Addressed:

This chapter has described the framework in which the approach to the linked themes of poverty, community and health is located. It has introduced the literature review of this thesis by touching on some of the factors associated with class and health, poverty and health and social networks and health. It has looked at some of the effects of increasing poverty and unemployment on deprived communities and describes evidence on the recent growth of poverty and changes in its social and spatial patterning, as well as latest statistical evidence on widening health inequalities.

The chapter looked briefly at current thinking on health inequalities which relates them to a lack of social cohesion in contemporary societies. The concept of social cohesion was examined and discussed, as well as additional contemporary political ideas of relevance to the interrelationship between poverty, community and health: social inclusion and communitarianism. Concepts which underpin the literature on health inequalities and social networks and health have not been explored here; they are considered in the next chapter.

A question remains as to whether we can identify contemporary kinds of local conditions which make for social cohesion and which are likely to be of benefit to health. What role do social networks play? What changes in community life in today's inner city communities have impacted negatively on health? Interestingly the Roseto study appeared to demonstrate that social organisation, values and participation in organisations were interdependent.

Additional questions include: What difference does the locality make to health? Which factors are important? What is the role of social networks in the relationship between poverty and health and place and health. An important strand is the difference that place can make, a difference over and

above the socio-economic characteristics of residents. Another concerns the links between social networks and values and attitudes. These are the themes explored in the thesis which follows.

2. KEY CONCEPTS

This chapter looks at some of the concepts which have underpinned research into a) social inequalities in health, and b) social networks and health. They are health, inequality, class, and community. It also considers additional key concepts of relevance to this research, namely participation and solidarity. Because there is a debate in the health literature on the importance of place for health, it also further examines research and discourse on 'concentrated poverty' and related poverty concepts.

Health

A problem in investigating work on health and illness concerns the lack of an agreed definition of the concept. In general terms, we have a medical model of health, and a social model. The medical model focuses on disease, biology and physiology and the role of doctors in curing malfunctions. Although challenged by the 19th century public health tradition of Chadwick and by the work of Engels (Engels 1844) which drew attention to the connections between poor living and working conditions and ill health and premature death, it remained the dominant model of health and illness until the later decades of the 20th century. During the 1970s, certain writers began to question the efficacy of medical intervention and to look at health determinants in other than a biological sense. Illich, for example, (Illich, 1977) argued that doctors caused more ill health than they cured while McKeown sought to reduce the importance of the role of medical intervention to a minor one in its effect on the reduction of 19th century killer diseases. He demonstrated instead the historical importance of social and environmental factors, notably food, public hygiene and contraception, (McKeown, 1976).

A social model of health is still in its developmental stage. McKeown's work on the historical importance of social and environmental factors in the reduction of the incidence of 19th century diseases remains an important influence, particularly evident in the material deprivation approach to health inequalities,and most recently in the literature on healthy cities , (McKeown ,1976; Black 1980; Townsend 1988; Whitehead 1993; Phillimore and Beattie, 1994; Ashton, 1988). McKeown's approach to the concept of health appears restricted when compared to the World Health Organisation's concept of 'positive health'. The WHO moved away from a narrow, disease based focus to a broader, if utopian, concept of positive health, (Bowling, 1991). Health is "a state of physical, mental and social well being and not merely the absence of disease or infirmity" (WH0, 1948, p.100). Beyond this broad conceptualisation however, as Bowling points out, conceptual or operational definitions were not offered (Bowling, 1991,p.7).

The WHO concept of positive health appears to be open to many different interpretations. Townsend considers it to be a rather lame compromise, in that it favours an individual rather than a social orientation towards health (Townsend et al, 1988). Thunhurst however, interprets the WHO's concept of 'social' to refer to social policies, and the distribution of health between social groups, (Thunhurst, 1982). It has been suggested that 'positive health' could be described as the ability to cope with stressful situations, the maintenance of a strong social-support system, integration into the community, high morale and life satisfaction, psychological well-being, and even levels of physical fitness as well as physical health (Lamb et al, 1988; Bowling, 1991,p.7).

Bowling, in a review of the literature on positive health approaches, separates the concept of social health from that of quality of life. With social health, the emphasis is on social support systems as intervening factors between stressful life events or the environment and physical and mental health. (Bowling, 1991; Caplan, 1974; Cassel 1976). A movement away from the emphasis on the individual and their support systems is evident in those who define social health in terms of the degree to which people function adequately as members of a community, (Bowling, 1991). Lerner, for example, suggested that social well-being measures should focus on constructs of role -related coping, and family health. He hypothesised that socially healthy persons would be more able to cope successfully with day-to-day challenges arising from performance of major roles; would live in families that are more stable, integrated and cohesive; would be more likely to participate in community activities; and would be more likely to conform to societal norms (Bowling, 1991,p.8; Lerner, 1973). An emphasis on the individual is still however evident. Interestingly, anthropological studies describe a view of ill health which locates it in a breakdown of social relationships. Some simple societies (Totman, 1990) draw no distinction between the quality of a person's relations with others and their physical and mental state of health.

Quality of life is a catch all concept involving individual responses to the physical, mental and social effects of illness on daily living, and includes perceptions of well being, a basic level of satisfaction and a sense of self-worth, (Bowling, 1991). Bowling describes how, for Shin and Johnson, the quality of life is linked to 'the possession of resources necessary to the satisfaction of individual needs, wants and desires, participation in activities enabling personal development and self actualization and satisfactory comparison between oneself and others' (Bowling, 1991 p. 9; Shin and Johnson, 1978).

The Healthy Cities project, launched in 1986 by the World Health Organisation, adopted the

WHO's definition of positive, subjective health (WH0, 1948). However, an added on 'social ' and indeed political component is evident: the Healthy Cities Project supports participation in health care and services, as well as processes of community empowerment, (Davies and Kelly, 1993). The concept of participation is discussed below. Most of the literature on social inequalities in health (reviewed below in chapter 3) is not concerned with concepts such as these, but tends to relate to a medical model, and uses objective measures of morbidity, as well as mortality data. The social (and political) concepts of health however are useful for a understanding of the literature on social networks and health (reviewed below in chapter 4).

Inequality

The World Health Organisation, in adopting the goal of "health for all by the year 2000" (WHO, 1978) are calling for a reduction to inequalities in health of at least 25 %. Their emphasis is on observed inequalities between rich and poor nations and between rich and poor groups within nations. Since the WHO conference on primary health care took place in 1978, various research reports have shown that in nearly all European countries less well off groups have poorer life expectancies than the better off (Fox , 1989). Whilst some commentators have questioned the very goal of equality in health, believing it to be at best unobtainable, and at worst unnecessary (Institute of Economic Affairs, 1988), to others the findings of publications like the Black report (Black, 1980) came as something of a surprise. Welfare policies adopted by many countries after the Second World War were expected to put paid to patterns of differential morbidity and mortality. But it was not to be. As Hilary Graham has put it "it is in the experience of health and welfare that the social divisions of class, gender, race and age take on their human shape",(Graham, 1985, p.2).

Societies in which health inequalities persist, are generally considered unjust societies. The principle of social justice, argues Runciman, owes its existence to all three of the major political ideologies - Conservatism, Liberalism and Socialism. To Conservatives, social justice refers to a social hierarchy governed by a stable social system of interconnected rights and obligations To Liberals a socially just society is one in which hierarchy is still a dominant feature, but it is a hierarchy in which positions are achieved through competition between individuals, and not through dependence on social position. To Socialists, social justice is inextricably linked to goals of maximum social equality,[1] (Runciman, 1965). Tawney, writing in the 1930s, had provided a vision for reformers. Equality was elevated as the crucial goal. 'Equality' was an attack on the British

[1]Or at least was until recently. See the comment on the Labour Party and equality in chapter 1.

class system, a class system which was based not only on the inequitable distribution of wealth and other material resources, but of power, privilege, culture and opportunity too (Tawney 1931). Researchers in the field of health inequalities have tended to focus mainly on material determinants, and used a view of class which is one dimensional, that is, occupational class. Yet class, as EP Thompson so eloquently argued, is not something which can simply be reduced to any single dimension. It is an historical relationship, which happens when some people identify shared interests. Class consciousness is embodied in traditions, value systems, ideas and institutional forms, (Thompson, 1963).

Debates concerning the continuing relevance of class have tended to polarise between those who reject its contemporary utility, arguing for example that classes, instead of becoming more homogeneous as Marx expected, have become increasingly fragmented (Crewe, 1985), that distinctions between classes have been reduced, (Goldthorpe and Lockwood, 1968), that the working class has undergone changes which have weakened its solidarity and class consciousness, (Hobsbawm, 1981) that other identities - of family, location or ethnic group are more salient (Saunders 1990; Emmison and Western 1990) and those who, on the other hand maintain that ideological differences associated with class persist (Marshall 1988 ; Evans, 1993). Research indicates complexity: multi identities, of region, nation and family can co-exist with a strong sense of class. Indeed Devine identified class identity as something which united people whereas other identities differentiated them, (Devine, 1992a; 1992b).

During the 1980s the denial of class took a new form. Not only were some working class people seen to be becoming middle class, but those who remained were removed from the class structure altogether to form an 'underclass' (Murray 1990). In America, the category 'working class" no longer appears to exist at all; sociologists, like Wilson (1997) refer to the "respectable" poor as "middle class" and the "undeserving" as the "underclass".[2] Michael Harrington described the USA as a society where a working class exists but does not know it name (Harrington,1995).

American researchers have generally been less concerned with 'class' in patterns of health and illness than their British counterparts. Hollingshead and Redlich locate the denial of class in the American constitution: " the idea that stratification has any bearing on the diagnosis and treatment of disease runs counter to our cherished believes about equality" (Hollinghead and Redlich, 1958, p.6). Those who do incorporate measures of socio-economic position into their work, like Birkman

[2]Wilson has dropped the use of the term underclass for the ghetto poor.

and Breslaw (Birkman and Breslaw, 1983) tend to give the results of their findings which relate to social class much less prominence than they give to community factors.

Community

Durkheim asserts a strong influence on contemporary writings and research on 'community' as well as in discourse on cohesion, social inclusion, and exclusion, and indeed on some of the concepts of social health already discussed.[3] Concerned with the erosion of traditional forms of social solidarity, Durkheim was interested in identifying the sources of cohesion and solidarity in society. He distinguished between "mechanical solidarity" and "organic solidarity". The former was evident in traditional societies, and characterised by value consensus, conformity and ethnic homogeneity (Durkheim, 1893). In societies characterised by mechanical solidarity, social cohesion is maintained and social control is exercised by shared values and beliefs. Religion was the basis of solidarity in traditional society. In modern times mechanical solidarity is increasingly displaced by organic solidarity, a form of cohesion based upon relationships of exchange and co-operation, within a differentiated division of labour (Durkheim, 1893; Giddens, 1986). A problem with Durkheim and Durkhemian approaches to community is that it is not always clear whether it is the integration of the individual into the community which is seen a paramount, or the overall levels of interaction or cohesion of the community itself.

Importantly, Durkheim envisaged a key role for 'intervening institutions' in maintaining morality. Occupational associations for example, were seen as a way of balancing the increasing trend towards egoism and anomie with altruism. They would tighten the social fabric by providing individuals with more attachment and regulation (Taylor and Ashworth, 1987). They would provide intervening institutions between the increasingly centralising state on the one hand, and the mass of individuals on the other.

Durkheim believed that a consensus was possible, (Hawthorne, 1987). A generally recognised problem with Durkhemian theory is that it does not confront the question that beliefs are ideologies which help to legitimate the dominance of some groups over others. He has been accused of ignoring the role of interest groups in systems of subordination and domination (Giddens, 1986). Lockwood however, takes exception to the usual interpretation which stresses that Durkheim explains social order in terms of shared norms and values. Durkheim was aware, he argues, that social order is perfectly compatible with an imperfect solidarity based on 'moral despotism' or even

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[3] Durkheim's influence on the literature which links social networks to health is reviewed below in chapter 4

'conditional fatalism'. In the latter case people accept the status quo simply because they realise that they have no realistic chances of changing it, whereas in the former they believe that inequalities are inevitable and/or legitimate,(Mouzelis, 1993: Lockwood, 1992). [4]

Turning to contemporary approaches to community, it has become difficult to recognise Raymond Williams' warm description of community as a word which manages to avoid the connotations with conflict associated with class "and seems never to be used unfavourably" (Willmott, 1989, p.4; Williams, 1976). Definitions abound but Willmott's 'attachment community ' is succinct and all embracing. Two key elements are involved: one has to do with the extent and density of social relationships, and the other, "with perceptions, with the extent to which people feel a sense of identity with a place or group and of solidarity" with their fellows (Willmott, 1986, p.84). Research which has examined communities in relation to health has tended to focus on aspects of the first element: the extent (if not the density) of social relationships. The second, concerned with identity, and solidarity, elements of comunity shared with social class, remains relatively unexplored.

Community however, is a highly contested term. It can be used to refer to what only appeared to exist in the past, (Turner, 1988) or to describe a contemporary arena of both conflict and consensus. Some contemporary views deny the validity of spatial aspects of community, the important ties, for example, are said to be those which, like status or interests, transcend locality, (Hill, 1994;Mabileau, 1989; Day and Murdoch, 1993). Moreover, a strong sense of local attachment may be based on exclusion . Any sense of community becomes a myth, invoked to establish distance from others, (Cohen 1982; 1985). In its extreme form, the view holds that there is no singular community to be studied but rather a large shifting set of often antagonistic groups of residents (Abu Lughod, 1994). Moves to overcome the dichotomy between place and interest group have been made by Day and Murdoch for example, for whom "community" becomes the interaction of different social networks in specific contexts, (Day and Murdoch, 1993). Similarly, Janowitz and Suttles suggest that the locality provides a milieu in which the civic ideals of

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[4] Mouzelis suggests that all interactions are shaped by norms and resources that pertain to three dimensions: role/positional, dispositional and interactional/situational. Durkheim's account of social disorder focuses primarily on the role/social positional dimension, and ignores the situational/ interactional one, (Mouzelis, 1993). In Marx's case, as Lockwood points out, the emphasis is reversed. Here, the centre of the stage is taken by struggles over changing situational facilities. (Mouzelis, 1993, p.580.) Mouzelis thinks that at the centre of Durkheim's analysis are norms and resources pertaining to the role/ positional dimension, whereas at the centre of Marx's are norms and resources pertaining to the situational, interactional one.

democracy can be given meaning, the local community creates a potential interface between diverse interests and the opportunity to debate, sort, sift and balance each against the other. (Janowitz and Suttles, 1978; Bulmer, 1987).

Solidarity

Durkheim grappled to identify the sources of cohesion and solidarity in industrial society, (Bulmer 1987) and used the term solidarity to refer to co-operation between *unlike* individuals and between unlike groups (Durkheim, 1933). Allcorn and Marsh make a clear distinction between sociability and solidarity. Whereas friends are likely to share opinions and ideas, and will associate on equal terms, solidarity implies a readiness to stand by and support *other* individuals and groups if and when the need arises (Allcorn and Marsh, 1975). Traditional working class communities were clearly a source of solidarity and identity, as well as mutual aid (in a limited localised sense) (Frankenburg 1966; Bell and Newby 1971; Young and Willmot 1962); they were however, inward looking communities (Lockwood, 1966). Some of the factors associated with the traditional community - ties of neighbourhood, kin and regional culture may, it has been argued, inhibit wider solidarity rather than support it (Westergaard, 1965). Solidarity, for Baldwin, "is the child of interdependence " (Baldwin 1990 p33). It requires, he argues, some form of collective identity; it rests, in part, on an awareness of shared needs and risk. (Baldwin 1990). [5]

Chapter 1 mentioned the expectation evident in the community development literature that participation in community initiatives can foster shared interests and identities, as well as increase participation in decision making, improve services, and empower those involved. Chapter 4 reviews literature on participation and health. A recognition that "democracy can be an imperfect thing", imperfect because the poor and needy do not have voice and influence in the political process (Galbraith, 1994) is illustrative of one aspect of long term unease concerning the efficacy of systems of representative democracy. The focus on participation at the local level is another.[6]

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5 Bott suggested a link between the structure of a person's social networks - particularly the degree of density- and their social consciousness:" ...the more loose knit their networks, the greater the necessity for them to use constructed reference groups, abstract categories of person, as the referents of their norms and ideology" (Bott, 1957 p.223).

6 Concerns voiced in the middle of this century about anti-democratic tendencies of the interventionist state (Schonfield, 1969; Hayek 1960) are now expressed as a critique of "top down" policies which have allegedly served to disempower citizens and weaken self help and co-operation. Whether or not this perspective is accepted, it has become easy to recognise, as Weber did, the contradictions in and anti democratic tendencies of an increasingly centralising state. (Gerth and Mills, 1970). Participation was the antidote. When, in the 1960s

Advocates of a return to the ideals of participatory democracy [7] look to Mill, Rousseau, Cole and Marx. For Mill, participation was the most effective way of promoting self interests, safeguarding freedoms, and providing political education. (Pateman, 1970). Rousseau's ideal participation was co-operative, communal and altruistic (Rousseau 1762). Rousseau, and much later, Cole, looked forward to a society of small collaborative units where near universal participation would be the norm. For Cole, an essential precondition for effective political participation was participation and genuine power sharing in all aspects of social and economic life (Cole, 1919). Marx's feelings about the Paris commune had led him to believe that state power had to be crushed before participatory democracy could flourish. In the meantime class consciousness would be nourished by the participation which the existing system would allow, (Evans 1972 ; Marx 1891).

A real problem connected with local participation concerns democratic accountability and the representativeness of participating groups and individuals. If power is to be devolved, then how do we identify the representativeness of those it is devolved to, and how do we ensure the genuine inclusiveness of all groups that make up society? (Phillips ,A., 1994). The most deprived sectors of the community may remain outside the sphere of community initiatives (Willmot, 1989) and there will always be individuals - from a variety of backgrounds - who do not choose involvement.

The debate on whether place can have an effect on health over and above the socio- economic characteristics of residents was briefly introduced in chapter 1. The usefulness or otherwise of some current conceptual approaches to poverty for developing an understanding of the relationship between place and health and people and health, will now be considered.

Concentrated poverty

Area studies on health and deprivation generally identify areas on a scale of deprivation based on

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Lukes appealed for a return to classical participatory ideals (Lukes 1963), official reports followed which endorsed the new mood (Skeffington 1969; Barclay 1982). In the 1990's, participation is central to some strands of contemporary communitarian ideas on small scale 'natural' units (Bell, 1993; Etzioni 1995), as well as to "empowering" foci of community development work.

[7] Participation can be considered as a good in itself; as an essential component of democracy, or as antithetical to democracy. It has been linked to political instability, (Schumpeter 1943) and compulsion (Hayek 1960) (Orwell 1949). "Democracy" itself can be used descriptively, as for example, "...a competitive struggle for the peoples vote" (Schumpeter 1943 p 269), or can be defined as an ideal.

census indicators . Mapping poverty and deprivation is not altogether a value free exercise however. An unresolved tension can be identified in some of the theoretical poverty literature between approaches wary of stigmatising deprived areas (eg Townsend, 1979; Harrison, 1983; Goodwin, 1995) and approaches which seek to identify areas of 'concentrated poverty'. 'Concentration' is frequently used loosely, but sometimes more precisely: concentrated poverty areas are seen not only as places where large numbers of poor people live or where deprivation is particularly acute, but as places providing a fertile environment for the mushrooming of social problems of various kinds, (Murray, 1984;1994; Wilson, 1987).

The debate itself reflects earlier debates on structural or cultural causes of poverty.[8] Approaches to explaining poverty have tended to fall into two camps: those who seek structural explanations that lie outside an individual's control, and those who look to agency, in particular, to the behaviour and values of the poor, (Piachaud, 1997). The first approach tends to be sympathetic to the poor, the second, tends to attach blame to the poor for their condition. For Wilson, both are important: he stresses the importance of the interaction between the socio-economic changes in society and individuals' attitudes and behaviour. (Wilson, 1996).

Townsend was critical of what came to be known as the ecological fallacy, the erroneous assumption, derived from the Chicago School literature,[9] that all those living in a deprived area will suffer from the deprivations associated with it. He was equally critical of the notion that the poor are confined to poor or deprived areas (Townsend, 1979). As Goodwin later put it, we find urban poverty wherever we find the urban poor, (Goodwin, 1995) or Harrison, commenting on the poverty associated with the inner city "the poor, wherever they live, carry their own inner city round with them, like snails on their shells" (Harrison, 1983, p.24). When deprivation is too closely associated with certain geographical areas, there is a tendency, Townsend has argued, to "misrepresent national problems as area problems, with the effect of minimising their extent, and scapegoating whole communities" (Townsend, 1991, p.93). He recognises that : "The location of

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8 See for example Holman, R.(1978) *Poverty: explanations of social deprivation*, Robertson; Rutter, M, and Madge, N (1976) *Cycles of disadvantage: a review of research,* Heinemann; Lewis, O.(1965) *La Vida: a Puerto Rican family in the culture of poverty*, Secker and Warburg; Townsend, P (1979) *Poverty in the UK*, Penguin.

9 Sociologists of the Chicago School of the 1920s and 1930s, including E. Burgess, propounded principles of urban ecology. It was believed that there were natural areas or zones in cities, each inhabited by different social groupings. (See for example, Bell,C. and Newby, H (1971) *Community studies,* Allen and Unwin; Mathews, F. H. (1971) *Quest for American Sociology: Robert E. Park and the Chicago School*, McGill, Queens University Press.

problems of inner cities has to be traced back repeatedly to differences nationally between the social classes and especially to the social distribution of incomes and other resources...The problems of the inner city therefore, have to be traced to the distributions of employment, industry, wages, rented and owner occupied housing, public transport, and the rest. These problems are deepened or alleviated, in different mixes, by Government policies" (Townsend, 1991, p 122).

Yet the "inner city" became a code for deprivation and deviance during the 1980s, it came to represent, as MacGregor described it, a constellation of social problems. Policy makers were able to avoid poverty as the key issue, and to treat the "inner city" as an isolated policy issue. (MacGregor and Pimlott, 1991). The practice of stigmatising parts of London -like the demonising of the very poor - has a long history. Stedman Jones describes how, in the 19th century, the poorest parts of London were frequently described in the most derogatory of terms, as for example, a vast engine for depraving and degrading our population. Parts of the capital "the rookeries" were especially feared for their supposed contagious effects (Stedman Jones, 1976).

More recently American work on the geography of poverty has helped shape British attitudes . Researchers are often motivated by the belief that the social costs of poverty grow disproportionately with the rate of poverty in an area (Galster and Mincey, 1993). Some of these were sympathetic to the plight of the poor. Wilson identified the trend towards extreme poverty areas in America during the 1980s, (Wilson, 1987) a trend which is said to have continued and intensified. Wilson writes of ghettoes where impoverished, mostly black populations are trapped. Wilson's explanations are structural and economic. Changes in the world economy, and the collapse of traditional jobs in inner city areas has created a *concentration* effect of poverty, chronic joblessness for the low skilled, loss of male bread winners as role models, and growth in female headed households, (Wilson, 1996)[10].

Others take a less sympathetic view. Like their counterparts in 19th century London, they look not, as Wilson has done, to changing structures and growing poverty, but instead adopt a disease model, and identify a strong 'contagion effect' : "...the intense clustering of poor people [allegedly]

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10 Power argues that similar trends are emerging in Britain, but without the racial element. (Power,A "No ghettos here" *Guardian* 26.6.96.) There is evidence that areas containing large proportions of socially rented housing, are also increasingly becoming areas of concentrated poverty.(JRF, 1994). Power's research showed that in the most difficult to let areas, levels of unemployment were more than three times the average, the concentration of one parent families was four times greater and the proportion of children obtaining no GCSE passes was over four times the average, (Power and Tunstall, 1995).

leads to a concentration of other deleterious social and economic circumstances associated with poverty...crime, violence, welfare dependency, family disruption and educational failure." (Massey 1994, p. 1153). For Charles Murray for example, illegitimacy, crime and unemployment reinforce each other in small communities, producing a geographically concentrated underclass, (Murray, 1984 ; 1994). We don't have to accept the validity of contagion theories to recognise however that the poor are more likely to live in areas where there are other poor people. Britain's experience of economic, social and political restructuring during the 1980s may have helped to make this even more likely. As Green has argued, restructuring processes have been spatially uneven in their magnitude :" The operations of labour and housing markets interact to produce spatial concentrations of people with similar characteristics : employment vulnerability reduces choice of residence", (Green, 1994 p.3.)

Social isolation and exclusion

Evidence and discourse on the spatial concentration of poverty and deprivation have become linked to concepts of social isolation and to social exclusion. Both are somewhat amorphous terms, lacking generally accepted definitions. Social exclusion dominates the European debate, (Room, 1995). The EU definition of poverty is relevant here: "The poor shall be taken to mean persons, families, and groups of persons where resources (material, cultural and social) are so limited as to exclude them from the minimum acceptable way of life in the member states in which they live" (Bruto da Costa, 1984,p.2). Room identifies differences in current usage of the terms poverty and exclusion. The notion of poverty is primarily focused on distributional issues and concerns the lack of resources at the disposal of an individual or a household. In contrast, social exclusion focuses primarily on relational issues, on inadequate social participation, lack of social integration and lack of power (Room, 1995). For Walker, unlike the use of the term poverty- which can encourage 'blaming the poor' attitudes, social exclusion emphasises society's role in excluding some people from full participation, (Walker, R., 1997.) There are clear links with Marshall's concept of 'citizenship'(Marshall, 1950).

For some, "social exclusion", encompasses localities as well as individuals and groups. All three are seen as disenfranchised from mainstream economic, social and political life. Social exclusion, it has been claimed, builds on Townsend's earlier concept of social deprivation (Hardy et al, 1994; Spicker, 1996.) However, the spatial element now embraced by "social exclusion", did not feature in Townsend's earlier concept. It is the spatial concentration of the poor which is now seen as resulting in their isolation or segregation. An aspect of this exclusion - and one not encompassed by "social deprivation"-is a fear that the spatially concentrated poor may become cut off from

mainstream *values*, a concern which can be traced to the "culture of poverty" theories of Oscar Lewis (Lewis, 1965) and beyond , and subsequently re-interpreted by, amongst others, Sir Keith Joseph, who identified a ' cycle of deprivation' (Joseph, 1972).

There are similarities between the concepts of social isolation and social exclusion and the two appear to be sometimes used interchangeably. 'Social isolation' can refer to an individual's lack of integration into the community - and there are clear links here with 'social deprivation'- or it can refer to the lack of integration of a group- such as the poor- and may be linked to spatial concentration. Green adopts a variant of the latter approach: "The hypothesis that concentration and isolation are related is plausible" she suggests, "in that a spatially concentrated or segregated group would be expected to have less contact with other groups than would one whose members were evenly distributed throughout a geographical area" (Green, 1994, p.3).

However, social deprivation, the inability to participate in the normal life of the community, is, for Townsend, very much linked to lack of income (Townsend, 87). "Multiple deprivation" can involve people avoiding one form of deprivation only by submitting others. Some families maintain household amenities, and meet some of the needs of their children, only by shutting themselves off from their neighbours and from friendships at work, (Townsend, 1981). Kempson's study of poor families supports the Townsend view: families who maintained tight control of their budget did so through sacrificing their material welfare and their social participation, (Kempson et al, 1994).

Two competing paradigms are evident in these discourses on poverty. The first stresses culture and values, the second, structure and resources. To what extent are structure and values, as Wilson suggests, connected? Are there distinctive forces at work in new features of urban life and are they relevant to health? How helpful are the concepts of 'concentrated poverty' and 'social exclusion' and related concepts for looking at health patterns and experiences in poor areas? As indicated earlier, a number of problems associated with poverty, including ill health are said to intensify in areas where high concentrations of poverty and deprivation are found (Massey, 1994). Whether such effects relate principally to the characteristics and levels of deprivation experienced by those living there, to individual social isolation and/ or breakdown of communities, to the concentration of poverty and the allegedly allied social exclusion of the poor from the mainstream, to certain values, cultures or behaviours, or to relatively inadequate resources and services available in deprived neighbourhoods all remains to be disentangled. It is sometimes argued for example, that in what Philo calls the UK's 'poor places' that services are poorer than elsewhere, and that this is, in part a function of economic decline (of the sort all too evident in the region selected for the case

study in this thesis) but also of the lack of bargaining power of residents in such places, (Philo, 1995).

What this chapter has not attempted to explore is the role of social networks, but it is networks which could be seen to provide a linkage to many of the concepts touched on here. Social networks are involved in social conceptions of health and well being, in aspects of class and solidarity- who people live near to, mix with, identify with for example- and most clearly in community life and participation. Concentrated poverty, social isolation, and social exclusion, all imply some form of restricted social networks. Chapter 4 reviews the literature on social networks, and social networks and health. In the meantime, 'social capital' theory, derived from Tocqueville (1835), is relevant here also, and provides a bridging concept. Social capital has been defined as those features of social organisation, such as civic participation, norms of reciprocity, and trust, that facilitate co-operation for mutual benefit, (Kawachi et al, 1997, p.1491; Putnam, 1995; Putnam et al, 1993). Trust and co-operation facilitate access to scarce resources, (Burns and Taylor, 1997). By social capital Putnam means "features of social life - networks, norms and trust- that enable participants to act together more effectively to pursue shared objectives...to the extent that the norms, networks and trust link substantial sectors of the community and span underlying social cleavages- to the extent that the social capital is of a bridging sort- then the enhanced co-operation is likely to serve broader interests and to be widely welcomed,' (Putnam, 1995, pp 664-5). Moreover, Putnam argues that social capital- derived from sports clubs, co-operatives, mutual aid societies, and voluntary associations- is an essential underpinning of local government. Interestingly, he noted that in the Italian regions he studied, there was a link between stronger civic community, as evidenced by participation in civic life, and lower infant morality (Putnam et al, 1993). For Kawachi et al, "Social capital is thus a community-level ('ecologic') variable whose counterpart at the individual level is measured by a person's social networks" (Kawachi et al, 1997, p.1491-1492).

Co-operation and participation were themes running through the work of nineteenth and early twentieth century associational socialists, as well as Rousseau before them. They were also linked to egalitarianism. We have inherited optimistic beliefs about human capabilities from the enlightenment, the belief for example that human beings are perfectly capable of organising themselves into co-operative , egalitarian and self governing communities (Miliband, R., 1994). These ideas were sustained in the work of William Morris, in the Owenite co-operative movement, and in the guild socialism of G.D.H. Cole. For Owen, co-operation was the moral basis of social life; for Morris, 'community' happened when competition gave way to co-operation, (Owen, 1977; Harrison 1969; Morris 1979). The utopianism of Morris and Owen gave us a vision of what could be. Cole provided a detailed scheme of how a participatory society might be organised. His small

communities and their various co-operatives and associations would have democratic, structural links with the wider social, political and economic society, but there would be no compulsion. (Cole 1919; 1950; 1920).

3. SOCIAL AND SPATIAL INEQUALITIES IN HEALTH

Concepts discussed in the last chapter included some which encompassed the notion that there are forces at work in poor areas over and above the poverty of their residents. Parallel concerns are evident in the health literature, where, as indicated earlier, there is an ongoing debate about whether poor health evident in deprived areas is simply due to the socio-economic characteristics of residents, or whether additional features are involved. This chapter reviews the literature on social inequalities in health and looks at both people and places. It begins with an examination of research on social class and health, and looks at the complexities of the relationship between social class, gender, and deprivation - both material and social - in relation to health. Individual aspects of deprivation examined include income and unemployment. To identify some of the social and economic factors impacting on health inequalities at the national scale, contemporary patterns of both health inequalities and poverty are contrasted with the 1940s. The chapter goes on to review the literature on area inequalities in health, and identifies possible reasons for anomalies.

POOR PEOPLE

Class and health

When the Black Report on *Inequalities in health* (Black 1980) appeared , it received a hostile reaction from the Government. Its central argument, and one which has been supported by a mass of evidence since, was that class, poverty and ill health are inextricably linked. The Black working group, in reviewing evidence on inequalities in health, and in analysing official statistics on trends in mortality, demonstrated that "despite more than thirty years of a National Health Service expressly committed to offering equal care for all, there remains a marked class gradient in standards of health" (Black, 1980, p 15). Unskilled workers in social class V had, for example, nearly twice the chance of dying young , that is before retirement age, than professionals and managers in social class I, (see Appendix 1). Statistics made available by the Office of Population Census and Surveys in 1986 demonstrated a continued widening of the trend towards increasing inequalities. Both the decennial Supplement on Occupational Mortality for 1979-83, and the Longitudinal Study on death rates of a 1% sample of the population followed up from the 1981 census, show a widening mortality gap between occupational classes (see appendix 2). [1] The continuing salience of class to health

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1 It is perhaps indicative of a certain amount of discomfort felt in Government circles that the statistics were not made available in their usual, summarized form, but in a jumble of inaccessible fiche instead. Moreover, the OPCS seemingly rubbished, or were asked to rubbish, their own statistics (see Appendix 2 note iii). The table reproduced in Appendix 2, though included in the

status continues to be confirmed. As noted in chapter one, latest Government figures suggest that class related health inequalities continue in much the same pattern across all social classes and are widening, at least for males in unskilled groups in relation to other class groupings, (Drever et al , 1996). A compendium on occupational health confirms the trends outlined by statistics based on social class. For both men and women, the highest mortality was among unskilled labourers and textile workers, and lowest in managerial jobs, (OPCS and Health and Safety Executive, 1995). It is not only adults who are affected. Babies of fathers in unskilled manual occupations had an infant mortality rate 87% higher than the babies of fathers in professional occupations in 1995, (Office for National Statistics , 1996).

The Black working group came to the conclusion that the predominant *explanation* for inequalities in health lay in the material circumstances and conditions of peoples's lives, in material deprivation. Since then studies of unemployment, work conditions , housing, environmental pollution, low income and specific occupations as well as area of residence and their effects on morbidity and mortality now, as Townsend puts it, amount to a formidable array of evidence, (Townsend, 1988). [2] Official statistics and surveys have linked deprivation to mental as well as physical health and premature mortality. For example, people living in rented rather than owned accommodation, as well as women, people living alone, urban dwellers, and the unemployed were most likely to have had some kind of neurotic health problem (mostly depression and anxiety). Unemployed and economically inactive people were more than twice as likely to have psychiatric disorders compared to those working full time (OPCS 1995 b).

Work in what the Institute of Economic affairs calls the "post Black industry" (IEA, 1988) has tended to take one of two forms. The first concentrates on alternative indices of socioeconomic position to social class, such as housing tenure, access to a car, employment status, overcrowding, income, gender, ethnicity, as well as locality. The second has been to a certain extent hostile to Black's findings and conclusions. It is critical for example, of its alleged overdependence on mortality statistics; of the inadequacy of occupational class as a measure of inequality; and of the concept used to explain their findings, that is, material deprivation, (See eg Illsey, 1967 ; Le Grand , 1986).

OPCS press release, was not included in the report itself.

2 Discussions of the evidence, as well as of alternative explanations, can be found in Whitehead (1987); Wilkinson (1986); Smith (1990); Payne (1991) Kumar (1993) Benzeval et al (1995); Filakti and Fox (1995).

It is sometimes argued that the picture of seemingly growing health inequalities is simply an "artefact", that for example, mortality statistics, because of possible discrepancies between occupation as recorded on the death certificate and on the census return, are unreliable, (Fox, Goldblatt and Jones 1986). It has been pointed out however (Whitehead, 1987;Smith, 1990) that the OPCS *Longitudinal study* which follows up a one percent post census sample, has been designed to overcome any such problems inherent in the Decennial supplement, and yet produces similar results. A more basic critique of Black has been that, in limiting attention to mortality statistics, whole areas of illness not culminating in death have been disregarded. However, studies which have focused on morbidity demonstrated the existence of similar class related gradients *in morbidity* to those found in the evidence on mortality. Blaxter's Health and Lifestyles Survey (HALS) (Blaxter 1990) into the health and lifestyles of a large sample of the British population, did so for example. Similarly, national studies of self reported illness, reveal that rates of "limiting long standing illness" (as defined in the General Household Survey) rise with falling socio-economic status (as measured by occupational class) and are three times as high among manual males and females as they are among their professional counterparts, (General Household Survey, 1978). Secondary analysis of both 1985 GHS data and of the 1985-88 UK disability survey confirms the continuing salience of class in structuring variations in disability-free life-expectancy. Bebbington calculated that men in social class I are likely to benefit from as much as 9 years more healthy life than men in social class V. A particularly interesting finding was that chronic disabling ill health was as much related to fathers occupation as to own, (Bebbington, 1993) .

Some commentators however have been unhappy with what they consider to be the uncertain reliability of subjective measures of health like that of self report used in these and similar morbidity studies. Carr Hill for example, has argued for research which utilises objective measures, particularly of physical observations including birth weight, height and obesity (Carr Hill, 1987). Since (and in some cases before) he wrote, studies have been conducted on the relationship between height and class (Knight, 1984), on low birth weight and deprivation (Townsend, Phillimore and Beattie, 1988) and on obesity and deprivation (Payne et al, 1993). Moreover, it has been shown that self assessed health is a reasonably accurate indicator of future mortality (Wannamethee, 1991;Blaxter, 1990).

A second critique of Black's use of official statistics concerns problems associated with the Registrar General's scale of social class used in these statistics. Illsey and Le Grand for example have suggested that the figures may have been distorted and exaggerated by changes in the size and

composition of social classes over time (Le Grand 1986; Illsey 1967; Laurence 1986). Continuing health inequalities are said to be largely a reflection of the high mortality of a small and shrinking section of the population (Illsey, 1986). Another criticism concerns the validity of statistics in which married women have been classified along with the occupation of their husbands.

In the case of women, researchers have long been unhappy with the "gender blind " approach of many official statistics. The relationship between women's poverty and their health experience , argues Payne for example, is obscured by the preoccupation of much research with both male mortality and a measure of class based on male occupations and the household as a unit of consumption. The 1986 decennial supplement (OPCS, 1986) presented mortality rates for women classified according to their own occupation at death (for all women),classified according to their husband's occupation (for married women) and classified according to their own occupation (for single women). Women's higher social class is as much associated with a better chance of surviving beyond retirement age as it is for men. The strength of the relationship however, is least strong for married women according to their own occupations (Payne, 1991). Marital status, as well as responsibility for childcare may be a complicating factor, as may be the unequal spread of men and women through the Registrar General's scale. Women, for example, are concentrated in classes II and III non manual, (39% of all women) while 60% of men are found in skilled and unskilled manual work. Women workers are more likely to be found further up the scale than men, but, in reality their work is poorly paid and of low status (Payne, 1991). Stacey has argued that class needs to be conceptualised as relating to the private relations of reproduction as well as to the public sphere of production (Oakley, 1991). Studies on women's *morbidity* are interesting here. Arber and Ginn, for example. using data from the 1985 General Household Survey (GHS), examined the relationship between self-assessed health or functional disability on the one hand, and the social class of elderly women on the other. Two measures of class were used: the woman's own last occupation and the more usual approach of taking the husband's last occupation. When the results of each were compared, little difference was found in the strength of association between own last occupational class and health and husbands own last occupational class and health, (Arber and Ginn, 1993).

The problem remains that statistics utilising the Registrar General's scale of occupational class may present a distorted or exaggerated picture of social inequalities in health. Investigations using alternative measures to that of social class however have led to claims that the Black Report, far from overstating the impact of social inequalities in health, may actually have *understated it.* A set of studies on the health of civil servants looked at differences in morbidity and mortality between

different grades within the same occupation, (Marmot et al, 1991). Marmot and his colleagues found more than a three fold difference in mortality between the lowest and highest grades in the service. Similar grade gradients were found for self reported morbidity. Another study found an inverse relation between mortality from coronary heart disease and rank, for men in the British army (Oleman, 1981). Illsey amongst others have suggested that self selection should be incorporated into any explanation of health inequalities: occupational status is determined by an individual's health and not the other way round. Follow up studies (including the Whitehall Study) have suggested however that the contribution made by ill health to social mobility is small, (Wilkinson, 1986, 1989; Whiteside, 1988; Marmot et al, 1991).

One of the most contentious areas for debate has focused on the explanation for health inequalities which looks at culture and behaviour. The arguments have been fuelled by evidence provided by the epidemiological tradition in which risks in behaviour and consumption - alcohol, diet, smoking and exercise - are linked to patterns of ill health. Although researchers in the health inequalities field do not deny that certain behaviours are detrimental to health, and that risk behaviours may vary with class, there is wide disagreement on the reasons why risk factors are distributed in the way they are, and on the weight of behavioural relative to socioeconomic factors. An approach favoured by certain politicians , in an attempt to deny the effect of governmental policies on poverty during the 1980s and early 1990s, maintained however that certain people - particularly northerners, and even more particularly working class northerners, are unhealthy because they eat the wrong foods, drink too much, smoke too much and do so out of ignorance.[3] There are clear parallels between theories and strategies aimed at individualising the causes of *poverty* and those similarly employed to individualise the causes of ill health. The current arguments are not dissimilar to those provided by Sir Keith Joseph in the 1970s and more recently by Charles Murray on the British "underclass" (Joseph, 1972; Murray, 1990). They all seek to blame the poor for their own poverty and now for their ill health as well.

Some studies have run controls for some of the known risk factors. Marmot's Whitehall research did so, and found that controlling for smoking reduced the risk associated with grade only to a minor extent. (Marmot, 1991). Several reports have concentrated simply on the cost of eating healthily. A Health Education Authority report revealed that families on low incomes simply could not afford the most basic diet necessary to maintain good health, (HEA, 1989) while the National

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3 In 1988, the then Junior Health Minister, Edwina Curry, made comments like these on television when Townsend's work on health inequalities in the Northern Region was published.

Children's Homes found that 1 in 10 children under the age of 5 from families on low incomes go without food to eat at least once a month because parents cannot afford to buy it, (National Children's Home, 1991). Another study reported that up to two million British children are suffering from stunted growth and malnutrition, (School Milk Campaign, 1996). Findings like these put official statistics on childhood death, which reveal a health divide as dramatic as that for adults, in a clearer light.[4] Even the Government's own Chief Health Officer, Sir Donald Acheson, in his last annual report before retiring, admitted that there was a limit to how much could be achieved by encouraging people to lead healthier lives: "The issue" he said "is quite clear in health terms: that there is a link, and I suspect will continue to be a link between *deprivation* and ill health", (Department of Health, 1991,p.5).

Yet it would be misleading to dismiss the effects of culture on health too readily. As Townsend has described it: "Cultural artefacts and long standing customs of diet, clothing and childcare can produce significant variations in the health of minorities and specific local communities" (Townsend, 1990,p10). Risk factors such as smoking, drinking and diet may only explain a third of the social class gradient in coronary heart disease for example, (Department of Health, 1995) but smoking is the biggest case of premature death, (Deapartment of Health, 1992). Coronary Heart Disease is of particular interest because, according to the National Heart Forum, the poorest groups are becoming increasingly over-represented in the statistics, (Mihill, 1997).

Deprivation and health

Research in the late 1980s and 1990s has focused on the relationship between aspects of deprivation and health, and compared geographic areas in terms of levels of deprivation and health status, (Townsend et al, 1988; Eames et al, 1993; Phillimore and Morris 1991; Phillimore et al 1994; Drever and Whitehead, 1995; Dorling 1997). The focus now is as much on poor places as poor people.

Townsend's Northern England Health study for example, used broad measures of both health and deprivation and related them using regression analysis, (Townsend, 1988). Mortality ratios for 1981 - 83 were combined with statistics on permanent disability and sickness taken from the 1981 census, and data on low birth weight and slow development. Deprivation was represented by four indicators selected from the 1981 census: unemployment; lack of car ownership; lack of home

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4 See, eg , Kumar, 1993; Spencer 1996.

ownership, and overcrowding.[5] Of the individual indicators of ill health, permanent sickness and disability were found to have the strongest association with material deprivation. A combination of the four deprivation variables were found to "explain" as much as 65% of the variance in overall health across the region, a percentage which increases to 80% if the analysis is restricted to urban areas. A second phase of this study incorporated 1991 Census data and confirmed the association between deprivation and ill health, (Phillimore et al, 1994).

It is of course possible that the combination of census indicators which form the Townsend Index of Deprivation is not an appropriate or valid measure of deprivation. Additional studies however, utilising alternative indices have found the relationship between deprivation and ill health still held. Eames, Ben-Shlomo, and Marmot for example, utilised three separate deprivation indices: the Jarman, the Carstairs, and the Townsend. Their results demonstrated that increasing deprivation was significantly associated with mortality from all causes, from coronary heart disease, and from smoking related diseases, throughout the range of affluence, (Eames et al, 1993). A study by Drever and Whitehead on patterns of mortality for regions and local authorities in England and Wales and based on data for the years 1989-93 used the DOEs Index of Local Conditions, (amended).[6] This study also found a very strong relationship between mortality and deprivation at the local authority level. Mortality in the most deprived local authority was found to be more than 49% higher in males and 33% higher in females than in the least deprived local authority, (Drever and Whitehead, 1995).

It is important that deprivation indicators selected in surveys do adequately represent the poverty and deprivation experienced for their role in the generation of health inequalities to be properly understood. The methods chapter (chapter 5) considers issues associated with measures of poverty and deprivation when using official statistics. Here, approaches to poverty and deprivation are further considered.

The literature on social inequalities in health has traditionally focused on material deprivation to the neglect of aspects of social deprivation Material deprivation, for Townsend, refers to a lack of material goods of modern life or the immediately surrounding material facilities or amenities. Social deprivation, on the other hand, means that people may not have access to ordinary social customs,

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5 Generally now known as the Townsend index.

6 The ILC variable for mortality was excluded so as not to confound results. For a list of variables in the ILC as well as Carstairs and Jarman see chapter 5.

activities and relationships, (Townsend, 1987 p. 86). The two are seen as interconnected, some families meet some of the needs of their children and households, only by shutting themselves off from their neighbours and from friendships at work, (Townsend , 1981). The implications for peoples' social networks are clear.

To access aspects of social deprivation,. Townsend, Corrigan and Kowarzika used interviews to supplement census data as part of a survey carried out in 1985-86 in Greater London, and utilised more than 70 indicators of deprivation (Townsend, 1991). Differences between wards were found to be more stark when the wider measures of social and material deprivation were brought into the picture, a finding which incidentally is confirmed elsewhere at the level of the individual. A conclusion from Blaxter's research for example, concerned the combined effects of low income and lack of social contact on the health of an individual: they were always greater than the effects of one of these alone, (Blaxter, 1990). In Townsend's poorer boroughs and wards, more were unemployed, had gone without food in the last 12 months, had not had a holiday, their children had nowhere to play, lived in poor housing, complained about pollution and environmental issues, felt lonely, and had few sources of social support. In addition, a higher proportion of the population expressed anxieties about making ends meet, about debt, unemployment or their children's future. Self reported ill health was much worse in the most deprived boroughs than the least. In Hackney for example, as many as 36 per cent said that their health was poor or only fair, compared to only 23 per cent in Bromley, and more in Hackney reported that they had suffered from depression. The mortality rate in the most deprived wards in Greater London was nearly double that in the least deprived, (Townsend, 1991).

Secondary analysis on Townsend's 'Survey of Londoners Living Standards' was conducted by the Kings Fund. They compared subjective health status - an illness episode during the previous two weeks and experience of major health problems during the past year-with deprivation.[7] Their results indicated that only one half of the most materially and socially deprived of the survey respondents

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7 Indicators used to capture material deprivation concerned diet, housing, environmental hazards, working conditions, clothing, consumer durables, and local facilities. For social deprivation, they were employment rights, integration into the community- ie being alone and isolated from people, relatively unsafe in surrounding streets, racial harassment, moved house 3 or more times in last 5 years, formal participation in social institutions, recreation, family activity, educational attainment.

report themselves as being in good health, compared with almost 90% of the least deprived. Children whose parents experience high levels of deprivation are nearly nine times as likely to have only fair or poor health as the least deprived children. They suggest that the most disadvantaged groups might suffer disproportionately from the cumulative impact of different forms of deprivation, (Benzeval et al, 1992).

The importance of some forms of deprivation may vary according to gender. The King's Fund team's analysis of both the HALS and SLLS indicated that material deprivation and excessive drinking is more significant for men's poor health, while for women social deprivation appears to be more important. In addition, men are more likely to report poor health if they live alone, whereas it is *perceptions* of loneliness regardless of household circumstances which seem to be important for women, (Benzeval et al, 1992). A study by Clarke and Sloggett confirmed the relationship between women's increased risk of mortality and morbidity and housing tenure and car access, but also found that single women and lone parents were especially at risk, (Clarke and Sloggett, 1995).

Unemployment and health

Research into the health effects of unemployment is particularly valuable because the experience of unemployment spans aspects of both material deprivation and social deprivation. Research has consistently shown that unemployed people report diminished levels of *psychological* health in comparison with their employed counterparts, and that unemployment is positively correlated with *morbidity* and also with increased *deaths*, (Graetz, 1993; Whitehead 1993; Townsend, 1988; Payne, 1993; Moser 1986; Morris et al 1994; OPCS, 1996). Economic insecurity in general has been linked to increased mortality (Brenner,1979) and similar causative paths have been suggested for psychological distress, (Gaillie, 1994; Pearlin, 19 81; Whelan, 1993; Bartley, 1994). The evidence is strong though sometimes contradictory. There is some disagreement for example on the strength of the relationship between women's unemployment and ill health.[8]

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8 Although there is substantial evidence on the impact of unemployment on the psychological health of men, there is less research evidence about the psychological consequences of unemployment for women, perhaps because it has been assumed that women's experience of both employment and unemployment may be different from that of men. Since women, suggest Gaillie

A number of studies have demonstrated a relationship between unemployment and physical ill health as indicated by low birth weight of the children of the unemployed for example, (Towsend et al, 1988) and by long standing illness (Townsend et al 1988; Payne, 1991; Whithead, 1993). In one study, Payne compared the prevalence of arthritis, depression, dyspepsia, obesity and respiratory symptoms with unemployment rates and Jarman Underprivileged Area scores amongst a random sample in Rotheram. "All of the morbidity measures showed positive correlations with both the Jarman score and with unemployment, [but] some, notably those relating to respiratory disease and depression, were much more strongly correlated than others, such as obesity ", (Payne et al., 1993, p.161). The authors concluded that unemployment is just as useful a proxy for morbidity as the Jarman score.. [9] [10]

Interpreting the data on unemployment and health is not easy, particularly, as both Bartley and Whiteside have indicated, it is fraught with methodological problems, (Bartley 1991; Whiteside 1988). Some of the criticisms levelled at evidence on class based health inequalities have been levelled at studies of health and unemployment. Morris Cook and Shaper's study (Morris et al, 1994) was designed to take account of both problems of distortion and self selection. The increased risk of premature mortality associated with unemployment was only slightly reduced after adjustment for socio -economic variables (town and social class), and health related behaviour (smoking , alcohol consumption and body weight). To allow for the effect of health selection, they used data which measured health and health related behaviour collected *before* the loss of employment. Their results suggested that non-employment even in apparently healthy men was associated with increasing mortality, (Morris et al 1994, p.1138). Similarly, longitudinal evidence

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et al, are typically in less skilled and less well paid and less satisfying work, its loss may be less dramatic, and may even ease the double burden of paid employment and domestic work. Gaillie et al found no evidence in their own research however that unemployment was any less harsh in its psychological health effects on unemployed women than on unemployed men, (Gaillie et al 1994, p 16).

9 The Jarman index is described in chapter 5

10 Respiratory disease -including asthma and TB-has traditionally been identified as a disease of the poor. Its incidence as been increasing quite dramatically in recent years, (Elliot 1995; Newnham 1996).

now confirms that unemployment has adverse consequences for psychological health and well being. It has been shown, for example, that on a variety of measures, there are significant differences between school leavers who find employment and those who became unemployed, but few differences while both groups are still in school (Graetz, 1993).

The evidence can at times be contradictory however. Interestingly, adverse health effects are not restricted to those who are officially unemployed, but affect those who have retired early also, and people who are threatened with redundancy, (Westergaard, 1985; Morris et al 1994). Brenner's classic structural investigation on recession in Britain and America demonstrates a direct relationship between unemployment and increased mortality, in this case from heart disease and alcohol related disorders, (Brenner, 1979). The peak in deaths from these causes occurs on average two to three years after unemployment was at its highest. Eyer's analysis of US data however led him to conclude that the death rate *rises* during booms and falls during depressions, (Eyer, 1977, a; b). Stress, as it is for Brenner, is the crucial causative mechanism, but it is the stress associated with the risks deriving from *work,* particularly during a boom, not non work which is to blame. He describes, for example how peaks of strike activity, coming very early in the upturn of the cycle correspond with the *low* in the death rate, and argues that strikes are an expression of the functions of mutually supportive networks. Drawing on Seashore s work (Seashore 1954), who demonstrated that workers with strong primary networks in the workplace had lower rates of coronary heart disease than workers who lacked them, Eyer argues that as the boom develops, solidarity disintegrates and health deteriorates, (Eyer, 1977a).

What does seem to be emerging from the work examined so far is a picture of health inequalities related to generalised disadvantage. People in social classes IV and V, are, during a recession, more likely to be unemployed. This is particularly true if their health is already below par, and people in this group have higher morbidity and mortality rates when working anyway, The unemployed are more likely to experience lower incomes than those in employment, but they are also more likely to come from low paid and insecure occupations.. While in work, the social solidarity of the workplace may have offered some protection against stress induced ill health. When out of work, the already disadvantaged groups suffer further disadvantage: they lose this protection. However studies have demonstrated that the adverse effects of unemployment are not restricted to the formerly most poorly paid workers. Moser et al found that an excess of 20-30% deaths remained

after the socio-economic position of the unemployed had been taken into account (Moser et al, 1986), while Morris et al's research suggests that the relative risk associated with loss of employment was no different for manual and non manual workers, (Morris et al 1994). Yet the anomalous case of Middlesborough, found by Phillimore and Morris to have a worse mortality rate yet similar levels of unemployment to those found in Sunderland, suggests perhaps that social class may have an added on effect *in certain conditions.* An interesting finding noted by the authors but not highlighted in their conclusions as a possible contributory factor in accounting for mortality differentials, was that the proportion of households with semi skilled and unskilled heads was appreciably higher in Middlesborough than in Sunderland (Phillimore and Morris, 1991). In another study however, Sloggett and Joshi, using a national sample taken from the OPCS Longitudinal Study, found that while certain deprivation factors- that is living in rented accommodation and no access to a car- was associated with a loss of life expectancy approaching 5 years, being of lower social class carried only a small excess risk for both sexes, (Soggett and Joshi, 1994).

Class, deprivation and health

Occupational class is generally linked with poverty and wealth in common sense terms. Just how the relationship operates to affect health is more complex however: That both occupational class and material deprivation continue to be salient for *morbidity* is demonstrated by two studies. A study using data from the HALS to explore the relationship between women's self assessed health status and their occupation, employment status, household composition and household income, found, after controlling for age and long standing illness or disability, that women's occupational group had the strongest influence on self-assessed health, (Macran et al, 1994). Arber and Ginn, using data from the 1985 GHS, examined the extent to which inequalities in health - as measured by self assessed health and functional disability - among elderly men and women in Britain are conditioned by their class and by their possession of material resources. They found that class based on the individual's own previous main occupation is strongly associated with the two measures of health for elderly women and men at all ages, (Arber and Ginn, 1991: 1993). Material deprivation and advantage - eg income, housing tenure, car ownership - was associated with health on both measures. The question as to whether previous labour market position and current material circumstances each have an independent effect on elderly people's health was examined using logistic regression. Previous occupational class, they concluded, is a more important determinant of disability among elderly

men and women than current material resources, but the latter were found to have an additional effect in contributing to better subjective health and an improved sense of well being (Arber and Ginn, 1993).

Should class, or deprivation be the focus of analysis? It is clear from the poverty literature that deprivation is a many faceted phenomenon and that there is no general agreement on the importance of its relationship to social class relative to other dimensions of social structure, such as gender and race. Gender appears to mediate between class or deprivation and its effects. Paradoxes emerge when the health experiences of women are compared with men. Women appear to suffer from more ill health, both physical and mental, at all stages of life than men. Yet men on average die earlier than women. Both health gaps are greatest for those in the poorest groups. Women on low incomes suffer more physical and psychological illness than their menfolks, but men in these groups are much more likely to experience premature mortality (Payne, S, 1991). The first, suggests Payne may be explained with regard to women's restricted access to scarce resources in the household. But not the second.

The relationship between poverty and women's health appears to be more complex than that for men. Married women classified by their husband's occupation display a similar mortality gap to men, but women classified by their own occupation, show less of a gap in mortality rates between classes. Payne suggests that the experience of poverty is different for women than it is for men, and that this affects the structure of ill health for women. Poor housing, for example, might affect women more than men, as might the struggle to care for a family on a low income (Payne, S, 1991). Stress and ill health were common amongst women with families who were not making ends meet in Kempson et al's study of low income families. However, those who managed to keep their heads above water did so by sacrificing their own needs and well being - including going without food and social participation, (Kempson et al, 1994). Recent research for the Joseph Rowntree Foundation demonstrated that 85% of mothers surveyed said that they sometimes went without things to provide for their children, while 1 in 20 went without food. Many of the latter were lone mothers on income support, (Middleton et al 1997). Clarke and Sloggett suggest that while for men unemployment and occupational class seem more important for health status, for women it is essential to consider the interactions between family roles, employment status and material circumstances, (Clarke and Sloggett, 1995, p 3).

Income

Deprivation is clearly a function of low income, as Townsend has argued, (Townsend, 1987). How important is income to health relative to other indices of disadvantage? Wilkinson argues that mortality statistics based on the Registrar General's scale of occupational classes under-represents the extent of inequalities, because the groupings are too diverse and include wide variations in income, (Wilkinson, 86). His historical analysis of twentieth century Britain relating changes in health to changes in income demonstrates a close association between death rates and changes in income levels, (Wilkinson 1989;Wilkinson 1990). The authors of the Health and Lifestyles Survey (Blaxter, 1990) also believed that the apparently strong association between social class and health is primarily an association of income and health, though they did admit that they were not altogether happy about the reliability of their income data. [11]

Although differences in income levels between social groups within individual countries can be related to the unequal distribution of health chances, there is no such relationship, it as been claimed, between differences in the standard of living *between* different countries and the *overall* standards of a nation's health, at least in the developed world. The healthiest societies - in terms of average health standards- in the developed world are not the richest ones, but ones with the most egalitarian income distribution, (Quick and Wilkinson, 1991). Rodgers, using cross sectional data from 56 countries, found that there was a tendency for life expectancy to be highest in those developed countries where income is distributed most equally, rather in those which are richest, (Rodgers, 1979, p. 350). Research by Le Grand on age at death in 17 developed countries confirmed Rodgers findings: average age at death was found to be closely related to income distribution but not to Gross Domestic Product per capita. (Le Grand, 1987). Those countries of the European Union that reduced the proportion of their population living in relative poverty, as measured by less than half average income, like France and Greece, enjoyed faster increases in life expectancy than those in which income inequalities increased. Similarly, it has been shown that American states with wider income inequalities also have higher mortality rates, (Wilkinson, 1996; Kennedy et al, 1996; Kaplan et al,

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11 There was some evidence in the HALS that the relationship between income and health may be mediated by age. Income did emerge as one of the primary determinants of health, but although men over 40 on low incomes were experiencing high levels of illness, for those under 40 income made little difference as long as there was a lack of social support, (Blaxter, 1990).

1996).

Arguably, what is not clear is the extent to which better national health standards are simply a reflection of the improved position of the poor. Wlkinson demonstrates that England and Wales have bigger income differences and wider class related infant mortality differentials than Sweden, and that Sweden's advantage is not just confined to the most deprived social groups, (Wilkinson, 1996). Yet the statistics he refers to make it clear that the biggest differences in mortality rates between England and Wales on the one hand, and Sweden on the other, occur when the poorest groups - classes IV, V, single parents and unclassified (no job last ten years or no social class)- are compared. Similarly, for adult men, Swedes in all social classes are advantaged in terms of mortality rates, but classes IV and V gain most. In other words, the Swedish poor are much better off in terms of health standards on these measures, than their British counterparts. This is likely to have a marked effect on average health standards.

A recent American study however suggests, not only that income inequality leads to increased mortality, but that it does so via disinvestment in social capital or declining levels of social cohesion and trust, (Kawachi et al, 1997). Using American General Social Survey data, Kawachi et al found that income inequality in American States was strongly correlated with both per capita group membership and with the proportion of people in each state who believed that people could be trusted. Both social trust and group membership were associated with total mortality, as well as rates from coronary heart disease, malignant neoplasms, and infant mortality.

WIDENING INEQUALITIES

A way of assessing the relevance of various deprivation factors to health is to look at changes in health inequalities over time and identify other contemporary social and economic changes. One of the objections raised to the findings of the Black report, and to conclusions drawn from official statistics on class and mortality, concerned the evidence that health inequalities appeared to be widening. Interpreting the mortality statistics became a politically motivated exercise, understandable, for, if real trends in health inequalities were being reflected then "the only solution to this deeply embedded inequality (like that of housing or income itself) is a massive redistribution" (Carr-Hill, 1987,p 510). The arguments incidentally closely parallelled those - no less politically directed - concerning the measurement of poverty during the 1980s.

Amongst academics, the debate focused on the questionable validity of using class related mortality statistics to make comparisons over time. Continuing health inequalities (so measured) it was argued for example, related to a small and ever decreasing section of the population, that is, unskilled manual workers, and deaths before 65 (Le Grand, 1986: Carr-Hill, 1987). Since these objections were raised however, as chapter one has indicated, research using 1991 census data has demonstrated a widening death gap between social classes, as well as a widening of differentials in mortality according to the degree of deprivation evident in an area (Whitehead, 1997; Phillimore et al.1994 ; Dorling, 1997).

There is much evidence to suggest that the familiar pattern of health inequalities narrowed in Britain during the 1940s, only to re-establish itself during the 1950s. 1950 stands out as the point in recent British history in which differentials in mortality were at their most egalitarian (Wilkinson 1989; Townsend, 1988). A narrower health gap in the 1940s compared to the 1980s and 1990s is evident from indicators other than mortality statistics. Data from a DHSS survey of adult heights for example demonstrated that differences in height (a rough guide to health) between manual and non manual groups gradually narrowed before the war and widened after it. The narrowest differences occur in the cohort which reached the middle of its growth period (eight years old) around 1950 (Knight, 1984).

Improvements in health inequality during the 1940s took place during a period of better health experiences for the nation as a whole. Winter has argued that the greatest improvements in life expectancy amongst the civilian population this century took place during the two war decades, that is, between 1911-21, and 1940-51 (Winter, 1988). Reasons for both improvements in general standards of health during the 1940s and for the diminishing of health inequalities are not hard to identify. The universal social welfare and health measures outlined by Beveridge and adopted during the latter part of the decade without doubt played a major part in both. The weakening of the principal of universality witnessed in the 1980s would be expected to have some effect in the opposite direction, but could not explain growing health inequalities in the 1950s, 1960s, and 1970s.[12] Social policy changes, important as they are, are not however, the sole picture. Winter

12 Comparative research has found an "unambiguous association between a high incidence of poverty and means tested welfare policies". Britain was one of the two countries in the West- the other was the USA- to experience the sharpest increase in poverty in the 1980s. In both

argues (following McKeown) that it was improvements in nutrition which were primarily responsible for the rapid increase in civilian life expectancy during the war, and that significantly, it was the poorest groups who were the particular beneficiaries. Better food improved resistance to infectious diseases - the decline in which was the major cause of death rate decline during the1940s - and rationing meant that food was distributed on a fairer basis than before (Winter, 1977; Winter, 1988).

Many essential goods were subsidised by the Government as well as rationed. Titmuss (1955) believed moves to reduce inequalities to be necessary in obtaining the co-operation of the masses in the war effort. He quoted from a Times leader published in 1940, shortly after Dunkirk : "It was a call for social justice: for the abolition of privilege, for a more equitable distribution of income and wealth; for drastic changes in the economic and social life of the country" (Titmuss, 1955, p. 108). The New York Herald Tribune went further: "Hitler is doing what centuries of English history have not accomplished - he is breaking down the class structure of England" (Marwick, 1970, p. 298). To describe wartime Britain as a classless society is nearly as absurd as describing Major's Britain as such (or indeed Blair's), but there is certainly evidence that it was more egalitarian in certain respects. Titmuss' "Dunkirk spirit", that spirit of social unity and community spirit was real to Marwick, even if only of temporary duration. Social classes mixed, he argued, in the services, in the air raid shelters, and in the billets of evacuees. If the substance of social unity did not however match the rhetoric, as MacGregor intimates (MacGregor 1981), if the shared value of equality was in large part a construct of the wartime propaganda machine, or if the heroism of the Blitz was more myth than reality (Caldor, 1991), peoples' *perceptions* of greater equality and of a generalised social solidarity may have been real enough.

As already indicated, there were definite shifts towards greater material equality during the war years and during the administration of the reforming Labour Government of 1945-51. Wilkinson's historical overview of income distribution for this century leads him to conclude that it was the trend towards more equitable distribution of income during the 1940s which, in 1951, produced the narrowest health gap between social classes on record. By 1961 the class gradient in death rates was firmly re-established and so, he argues, were trends towards a more inegalitarian distribution of

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countries one of the targets of public policy was to minimise the role of the welfare state in society, (Dufy, 1996).

income, (Wilkinson, 1989). Despite rising standards of living, it has been estimated that between 1953-4 and 1960 there was almost a sixty percent increase of the population living on less than 140 percent of the national assistance standard, (Abel Smith and Townsend, 1965).

Adjustments made to national assistance payments would, inevitably, by moving the goalposts, affect the measurement of poverty so defined, and Wilkinson may be overestimating the significance of these poverty figures. Indeed, the Seventh Report of the Royal Commission on the Distribution of Income and Wealth found that the share of income of the bottom half of the population was little different in 1976-77 from that in 1949 and concluded that the income distribution showed remarkable stability from year to year, (Atkinson, 1990). Research conducted by the Institute for Fiscal Studies for the Joseph Rowntree Foundation reveals that *income inequality in Britain narrowed under the Macmillan, Wilson, and Heath* governments with the numbers living in households on below half national average earnings falling from around 5 million to around 3 million between the early 60s and mid 70s. These improvements stopped in 1977 (Goodman and Webb, 1994). If mortality differentials between occupational groups were increasing in the 1960s and 1970s in the way that Black indicated (Black, 1980), then it cannot be assumed that income alone was responsible, despite Wilkinson's strong evidence that the structure of health inequality parallels that of income.

From 1979 onwards however, changes in income distribution have been dramatic. Official and research reports portray an unprecedented widening of income differentials. The growth in inequality which occurred in the UK in the 1980s reportedly dwarfed fluctuations in inequality seen in the previous two decades (Goodman and Webb, 1994). Oppenheim, commenting on DSS data published in 1990 put it thus: the share of income of the poorer sections of society is shrinking for the first time since the end of the second world war" (Oppenheim, 90, p.35). [13]

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13 The number of people living in relative poverty (as measured by households below half average income) nearly trebled, and the number of people living in absolute poverty (according to various measures including income support level) grew between 1979 and 1992. Moreover, poverty has deepened for the very poorest during the same period . The poorest one-tenth suffered a 17 per cent drop in real income after housing costs, whereas, top salaries continued to swell. It can be misleading to direct attention solely to the extreme lower end of the income distribution. Only the top three tenths of the population ranked by income achieved above average income growth between 1979 and 1991, and only the top fifth had a larger share of total income in 1990/91 than they had in 1981 (HBAI 1991/1992; 1993;Goodman 1994; Jenkins1994;Rowntree 1994;Social Trends 1994).

The burgeoning wealth of the rich has not trickled down to the rest of society, it has become more consolidated at the top. The trends acting to change the shape of the distribution of income in this country are significant. Commenting on HBAI figures which demonstrate that two thirds of the population now live in households with incomes below the average, Frank Field said " It is not the case that society has left behind what remains of the poor and the working class. It is rather, that the very, very rich have drawn still further away from the rest of us" (Field, 1993, p. 15). Westergaard notes the sociological significance of these income trends, arguing that the important line of social division is that which divides the top fifth of the income range from the rest. (Westergaard, 1992). The problem of inequality concerns the riches of a minority and the increasing poverty of the rest. Growing inequalities in income during the 1980s, are, as we have seen, reflected in widening health inequalities. There are also indications that the change in the shape of the income distribution may be reflected in health patterns also . The Northern Region research demonstrates that a clear worsening of mortality relative to the national level in the poorest fifth of wards was accompanied by little relative change in the second and middle fifths and *an improvement only in the most affluent 40% of wards* (Phillimore et al, 1994).

In contrast to the 1980s, it was the better off during the 1940s not the poorest who suffered from cuts in real incomes. [14] The poorest could be seen as the major beneficiaries to a range of policy changes. Both Winter (1977;1988) and Milward, (1984) have argued that those groups whose market position was poor before the war - the old, very young, disabled, previously unemployed, women, the unskilled, the low paid - were able to make the biggest gains. The research reports discussed in this chapter highlight the poor position of social classes IV and V - the semi-skilled and unskilled, and other poor groups, in the map of health inequalities in contemporary British society. In the 1940s, it was precisely those groups who benefitted most from the economic, social and policy changes peculiar to those years and whose health improved accordingly. When Wilkinson (1990) and Rodgers (1979) argue that the range of income distribution affects the health of a developed nation *as a whole* more than any increases in GDP, then it is possible that the

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14 "The total effect of income tax and price changes up to 1948 [was to cut] ... the real value of purchasing power in the hands of the top sixth by some 30%, and increase the purchasing power in the hands of the remainder by about 25%" (Sears in Milward, 1984 p.43). Sears calculated that post tax incomes amongst those whom he loosely categorised as working class increased by over 9% between 1938 and 1947, whilst decreasing among the middle class by 7%.

improvements in average health which they are observing, are, in no small part, simply reflections of health improvements in the poorest groups. That certainly seemed to be the case in the 1940s: the distribution of health inequalities narrowed and the average health of the civilian population improved. The changed position of the poorest social classes was instrumental in both measures.

In the 1990s, the picture can be seen to have reversed. Major changes in British society have in one sense, affected richer groups disproportionately. Improvements in their premature mortality rates are only a little less dramatic than their staggering improvements in income. In contrast, the position of the rest of British society in terms of health and deprivation, has at best remained static or at worst deteriorated, and there is evidence that the risk of poverty is spreading (Ford, 1996). In the 1940s the improved position of the poor appeared to make a major contribution towards narrowing health inequalities: in the 1980s and 1990s, the improved position of the rich appears to be making a major contribution to *increasing* health inequalities.

Objective and material changes are not the whole story however. A picture of national social solidarity and generalised desires for equality may have been exaggerated during the 1940s for propaganda purposes, but we might expect that perceptions of a more egalitarian society might be held by the poorest groups in particular; after all, they had made the most gains. The 1980s and early 1990s stand in sharp contrast. The ethos of inequality and of schism has been predominant. *Perceptions* of inequality, particularly amongst the poorest groups, may be particularly acute, and may, as Wilkinson has suggested, (Wilkindon 1990) have an added detrimental effect on health. The unskilled, the unemployed, disabled and long term sick, not to mention women, were quite suddenly *included* in British productive society in the 1940s. This, perhaps, was the basis of the reality of the 1940s solidarity: society was still divided, but not in such a way that one group was excluded from its benefits. Policies of *inclusion* in the 1940s appear to have led to quite dramatic improvements in the health of previously excluded groups. Policies of *exclusion,* of creating a peripheral workforce of casual workers and a growing army of unemployed living on low benefits and then insulting them with the stigmatising label of "the underclass" may be having the reverse effect in the 1980s and 1990s.

POOR PLACES

So far this chapter has demonstrated that being poor and working class clearly affects one's health

chances, as do national economic and social policies and aspects of social and economic change. To what extent can place of residence have an independent effect?

Research has produced substantial evidence on variations in morbidity and mortality between different areas, at regional, district and ward level, (Willmott, 1992; Drever and Whitehead 1995; Eames et al, 1993; Phillimore et al, 1994; Philo, 1995; Towsend et al, 1988, Townsend, 1991; Dorling 1997). Explanations for spatial differentials focus on the deprivation experienced by resident populations. A North/South divide has been identified, health chances are better in the south east, worse in the north, north west, Scotland and Wales (Curtis, 1995:Willmott, 1992). Interestingly, Lancashire had the highest mortality rates in England in 1838-44, a position which has persisted into the 1980s (MacIntyre, 1986). Recent research by Drever and Whitehead indicates that "the familiar geographic pattern of higher mortality in the north and north west and lower mortality in the south and east of the country has continued into the 1990s" (Drever and Whitehead, 1995, p. 19) while inner cities and peripheral estates have been shown to be a less favourable environment for good health and longevity than suburban and rural districts.

At the local authority district scale, the local authorities with higher mortality are still predominately in urban areas, with those in the North of England, the West and Inner London having the highest rates (Drever and Whitehead, 1995, p.20). Manchester had the highest death rate for men over the 1989- 93 period, and Corby for women. (OPCS , 1995). At the ward level, Townsend for example found that during the early 1980s mortality rates in the most deprived wards in London were nearly double those in the least deprived wards (Townsend, 1991). In the Northern region, Phillimore et al's data showed that mortality in the least deprived wards (as ranked by 1991 Census indicators based on the Townsend index) was one quarter the rate found in the most deprived wards, (Phillimore et al, 1994). Eames, Ben Shlomo and Marmot investigated the relationship between deprivation in electoral wards and premature mortality for each health authority in England. They concluded that deprivation of an area and premature mortality are strongly linked (Eames et al, 1993).

The literature on area studies has produced some interesting anomalies however. In some places for example, mortality and morbidity rates - particular the former- are worse than the deprivation levels of their populations would suggest, (Townsend et al , 1988; Phillimore and Morris, 1991; Eames et al, 1993) . London is generally seen as an anomaly in terms of health experience. Research

has suggested that London boroughs have lower rates of premature mortality and ill health than comparable areas - in terms of deprivation- than in the North (Willmott, 1992; 1994:Benzeval et al, 1992). The Kings Fund calculated however, that avoidable mortality rates in London were only slightly better than comparable districts elsewhere. They conclude from this that differences could not be due to the better availability for health services in the Capital. Although their results appear inconclusive, the Kings Fund team do suggest that the health status of Londoners might be seen to be better than in other directly comparable areas.(Benzeval et al, 1992,p. 56).

It has been suggested that anomalies in Britain may be related to pollution (Townsend et al,1988; Phillimore and Morris, 1991), to rapid change in - as opposed to constant levels of - unemployment (Phillimore and Morris, 1991), to demographic features (Goodwin, 1995;Curtis, 1995), to the cumulative effect of severe deprivation (Townsend 1991), to poor housing (Blackman, 1989), or to special factors connected with the local area - particularly its social and community life (Eames et al, 1993).

Eames et al's comparative analysis of premature mortality in the 14 regional health authorities of England and Wales indicated that although the North East Region had a similar profile of deprivation to the North Western Region, mortality was lower in North East Thames than in the North Western Region. The authors suggest two possible explanations . Firstly, that the deprivation indices may have a different social meaning in each region,[15] and secondly, that where a person lives may have a detrimental effect on health over and above the characteristics of the people who live there. They suggest that the effects of *where a person lives* should not be restricted to matters concerned with the physical environment but could relate to *communities,* Referring to Roseto in America they add: "Some evidence exists to support the importance of social cohesion, family stability and community solidarity in influencing mortality", (Eames et al, 1993, p. 1101).

The outstanding example of the difference place can make is found in the work by Wolf et al on Roseto, a largely Italian town in America which consistently produced considerably lower mortality rates than neighbouring - and similar in terms of income and occupations - towns until the 1960s,

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15 Similarly, Curtis has argued that "the relationship between social factors and health varies geographically,... the health need implications suggested by any one "deprivation" indicator may have to be interpreted differently from place to place..." (Curtis, 1995, p. 161).

when social changes took their effect, (Wolf, 1993). Roseto was characterised by population stability, strong family ties, a high degree of community participation, and cohesive and supportive community relationships. It was also characterised by a high degree of ethnic and social homogeneity, by an emphasis on religious traditions and intra ethnic marriage. Interestingly values of equality were evidenced by "absence of ostentation, even among the wealthy" (Egolf et al, 1992, p. 10890).

Does place make a difference?

Whilst some researchers argue that the majority or all of observed differences in health can be ultimately explained by the socio-economic characteristics and deprivation levels experienced by resident populations and reject explanations which encompass an 'ecological effect' others have suggested that place can have an independent effect, (Slogget and Joshi 1994; McIntyre et al 1993; Jones and Moon, 1993; Haan, et al,1987; Blaxter, 1990).

Sloggett and Joshi, using a national sample from the OPCS Longitudinal Study, investigated the association between level of deprivation in electoral wards and premature mortality among residents, before and after allowing for levels of individual or household deprivation. They concluded that "the excess mortality associated with residence in areas designated as deprived by census based indicators is wholly explained by the concentration in those areas of people with adverse personal or household socio-economic factors" (Sloggett and Joshi, 1994, p.1470). Rented accommodation and no access to a car had a particularly powerful effect, reducing life expectancy by approximately 5 years. Living in a highly deprived area did not appear to carry any excess risk over and above that associated with personal disadvantage. Conversely, disadvantaged individuals did not seem to receive any protection from risk by living in areas of relative affluence. They argue that " the evidence does not confirm any social miasma whereby the shorter life expectancy of disadvantaged people is further reduced if they live in close proximity to other disadvantaged people (Sloggett and Joshi, 1994, p. 1473). The authors recognise however that census indicators may not be precise enough to detect an ecological effect [16] and that mortality data is a restricted health indictor . They

16 Ecological studies are based on data aggregated at a particular geographical level. They assume homogeneity among individuals or households within the area of study, (Sloggett and Joshi 1994). The approach is derived from the Chicago school literature. Chicagoan philosophy includes the belief that cities select out of the population the individuals best suited to live in a particular region (Park, R E (1952) *Human Communities: the city and human ecology*, NY Free Press.

suggest that certain morbidities, such as psychological stress could be compounded by an ecological effect in highly deprived areas (Sloggett and Joshi, 1994).

Others have produced evidence which suggests that the higher death rates in deprived areas are not simply a function of the disproportionate number of socially disadvantaged individuals who live there. Haan et al's work on Almeda, California, for example, showed that area differences persisted after controlling for many individual level variables including age, sex, race, baseline physical health status, low income, lack of access to medical care, unemployment, education, health insurance coverage, and behavioural factors (Haan et al, 1987). Haan's work suggests that "over and above individual level attributes of deprivation, people of low socio-economic status may have poorer health because they tend to live in areas which in some ways are health damaging" (Mcintyre 1993, p. 219). Blaxter's survey on morbidity in this country found that cities and industrial areas seemed to have an independent effect, but that also, curiously, living in a high status area had a detrimental effect on the health of young women who were manual workers (Blaxter, 1990). Blaxter suggests that lack of social support may be a factor here.

Some health researchers argue that the difference that space makes ought to be taken more seriously (Jones and Moon, 1993; MacIntyre et al, 1993) and that we need to look at both people and places simultaneously. MacIntyre et al suggest that area needs to be considered as a mediating factor between class and health (Macintyre et al, 1993). "Just as 'social class' is often treated as though it explains things, rather than providing a starting point for more detailed examination of the processes producing health and illness, 'area' may be also treated as though its relationship with health is obvious." (McIntyre et al ,1993 p. 218). One's class position, does, in any case , as MacIntyre et al point out, largely predict the type of area in which one is likely to live. Which factors connected with the locality are likely to be important? Social, economic and cultural features of areas may, they suggest, be some of the mediating factors in the relationship between class and health. MacIntyre et al conceptualise socio-environmental influences on health as falling into five broad types: 1) physical features of the environment; 2) availability of healthy/unhealthy environments at home, at work, and at play; 3) local services; 4) the reputation of a neighbourhood, and 5) socio-cultural features of a neighbourhood. These include the political, economic, ethnic and religious history and current characteristics of the community, norms and values, the degree of community integration, levels of crime and community support.

Sooman and McIntyre looked at two areas in Glasgow known to differ in their socio-economic characteristics and in their mortality experience. Their surveys suggested that the opportunity structures in the poorer areas are less conducive to health or health promoting activities than in the better off areas. The better off area had more shops, cheaper food, better access to healthy recreation and more primary health care provision. The poorer areas had worse litter problems and residents were generally less satisfied with their area in terms of facilities, environment and neighbourliness, (Sooman et al.,95).

We cannot necessarily assume of course that what happens locally is important for people's everyday lives. Some may, for example, prefer to use services or interact with people outside their area of residence. These questions will be explored more fully in the next chapter which reviews the literature on community and social networks.

Research indicates that however we approach social position, those most disadvantaged experience the worst health. Occupational class may have its shortcomings as a tool of measurement, but the answer may not be to jettison class in favour of research into health which reduces people's experience to just income, or manual work, or housing tenure, or employment status, or any other single measure of socio-economic position, although it is certainly important to identify the extent of the contribution made by each. Class is as important for the health of women as it is for men, even if the processes are different, because women's experience of poverty is different to men's. A focus on the local *community* may help us to understand how some of these complex issues and dimensions of class and deprivation interact, and how their effects may vary in different social settings.

How can we account for the differing mortality experience of Londoners compared to other deprived areas? A number of explanations are possible. It could be for example, that differentials are connected to problems of time scale: London's worsening deprivation may yet be reflected in the Capital's mortality rate: London may yet "catch up" with areas whose experience of deprivation, unemployment and poverty have been more long term. At least six additional explanations are possible: 1) Different deprivation variables may have different meanings for the health of the population in London compared to elsewhere; 2)there may be important differences between the demographic profile of Londoners compared to elsewhere; 3) there may be regional cultural and behavioural differences (the Londoners don't eat as many chips as northerners theory); 4) we may

be missing something connected with the spatial patterning and measurement of poverty, issues connected with concentration, isolation etc.; 5) There may be something about London itself, its environment, its services; or 6) issues connected with community may play a role. Timescale and measurement issues are taken up in the Lea Valley case study in chapter 6. Community factors are unlikely to apply at the all London scale. They are however important for consideration at the micro level, and are explored on two housing estates in chapters 7 and 8.

Opportunities to lead healthy lives are more restricted, the literature has demonstrated, in poor areas compared to better off areas. But what are the variations between deprived areas themselves? Factors connected with community may help to account for anomalies in area based surveys of deprivation and health. Various community factors may also have a role in mediating between class and health. What factors of community or locality are important? The local case studies will investigate factors such as facilities, housing, community participation and perceptions of community, as well as those more amorphous features highlighted in the Roseto studies- social cohesion and solidarity. A question is, are there factors connected with the community, which mediate both socio-economic position and health on the one hand , and place and health on the other.? What role do social networks play? This thesis goes on to investigate the possibility that social networks may act as mediators between both socio-economic position and health, and place and health. Do social networks link poor people and poor places? The role of social networks in patterns of health and illness isexplored through the literature in the next chapter.

4. SOCIAL NETWORKS AND HEALTH AND THE MECHANISMS INVOLVED IN POVERTY, NETWORKS AND HEALTH

SOCIAL NETWORKS AND HEALTH

Social deprivation

Chapter 3, in reviewing the literature on class, deprivation and health, suggested that differences in health between deprived areas may to some extent be influenced by community factors. This chapter explores aspects of community which have been shown to influence health- people's social networks. Chapter 3 also illustrated the notion that to be poor is to be deprived in more than a material sense. Surveys reviewed demonstrated the adverse effect on health of 'social deprivation' as well as material deprivation. To be socially deprived involves the inability to participate in the normal life of the community, to lack access to ordinary social customs, activities and relationships, it involves a lack of integration into the community (Townsend 1987; 1993). Impoverished social networks go hand in hand with social deprivation.

Successive studies have shown that working class people have fewer friends and less involvement in organisations than their middle class counterparts (Bulmer, 1987;Willmott, 1987; Willmott 1986; Berkman and Breslaw, 1983). The social networks of the unemployed tend to be less extensive, or more restricted in some other way, than those of the employed. Their level of sociability with people outside the household is lower, their friends are more likely to be unemployed themselves, and they appear to gain less in the way of practical and emotional support than those in employment (Gaillie, 1994 a; b; Morris, 1992) In the case of medically at risk pregnant women, very limited contacts and inadequate support levels go together with material hardship (Oakley, 1992).

Birkman and her colleagues, for example, using a measure of social class of a five fold index of income combined by educational status, found that men and women of low socio-economic level ranked lower than those in the upper classes on most components of their index of social contact. The exception was contact with close friends and relatives, whom the authors suggest may be "an important source of support for poor people who lack other kinds of social connections" (Berkman and Breslaw, 1983,p. 135). The relatively wider social networks utilised by better off groups is a point noted by Willmott in his analysis of British research (Willmott, 1986). It is clear from all of this that the precise relationship between social class, social networks and health is complex and needing of further investigation.

Yet, the poor would appear to *need* social contact for benefit to their health more than the non poor. Social ties have been found to have the greatest protective impact on the health of those in the poorer sections of society. The Health and Lifestyles Survey (HALS) found "social support" to be protective to subjective aspects of health (self assessed) even in poor circumstances (Blaxter, 1990), and Whelan demonstrated that social support, of both a practical and emotional kind, has its strongest effect on psychological health *at the highest levels of deprivation* (Whelan, 1993). Whelan investigated the role of social support in mediating the psychological consequences of economic stress. He found the chronic stress associated with poverty to be the primary determinant of psychological distress, but that both instrumental (practical) and emotional support serve to buffer the effects of extreme life-style deprivation. He suggested that economic stress - associated with a lack of resources-has its most substantial effect when levels of social support are low.

Durkheim's influence

The emphasis in Britain until relatively recently was on material and structural determinants of health. American health studies, in contrast, have developed in part from the community studies approach of the Lynds and their successors as well as a sociological tradition which encompasses the work of Durkheim, Parsons and the Chicago school and seeks to examine the relationship between the individual, his or her community relations, and health. (Bell and Newby 1971;Lynd and Lynd 1929; Parsons 1951; Durkheim 1952).

Durkheim probably remains the single most important influence on contemporary American health studies, and indeed on community studies. Durkheim related rates of suicide to institutional features of late 19th century societies, to marriage, family life, widowhood, and religion (Durkheim, 1897; 1952). He was particularly interested in the weakening of social bonds which he associated with the decay of traditional society and the process of industrialisation,[1] and drew attention to relationships between a person's social integration and the suicide rate. Suicides, for Durkheim, were either egoistic, that is caused by a lack of meaningful social interaction; anomic, caused by a lack of norms and values, or altruistic, the rarer form which occurred when individuals were too closely integrated into the values of their society.

Egoistic suicide, "varies inversely with the degree of integration of the social groups of which the individual forms a part " (Durkheim 1952, p 290). Thus people who are married, or have large families were found by Durkheim to have lower suicide rates, as did communities where religion

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1 See also chapter 2.

(notably the Catholic religion) was more closely integrated into the community, (Giddens 1978;1971).

Anomic suicide is a state of moral deregulation linked to fluctuations of the economy in situations of both boom and slump. Ensuing instability causes social disruption and the weakening of the moral codes that normally regulate individuals' social actions. Both egoistic and anomic suicide are the product of social changes which undermine mechanical solidarity. Egoistic suicide is the unavoidable offshoot of the rise of individualism, and anomic is the outcome of a state of economic change. Altruistic suicide is found in those traditional societies where the existence of a strong conscience collective dominates the actions of individuals. Too much respect for societal values, does in this case, lead to altruistic suicide, (Durkheim 1952;Giddens 1978; Giddens 1971).

Although some accounts of Durkheim accuse him of adopting a crudely deterministic view of the individual which dissolves him or her into the social group, Taylor and Ashworth have argued that Durkheim recognised the relationship between the individual and the group as problematic. For Durkheim, the relationship between the individual and social components of human nature is shaped by the "collective consciousness" of the social group in which the individual participates (Taylor and Ashworth, 1987). The collective consciousness itself is determined by the relative strength of and balance between four moral forces: altruism- the commitment and obligation to a higher order outside the self; fatalism- predictable and inescapable limits to human action; egoism- autonomy and individualism; 4) anomie - uncertainty, ambiguity and change, (Taylor and Ashworth, 1987).

Social maladies of the time were, for Durkheim, the effect of 1) unbridled egoism, or 2) the lack of moral regulation, or 3) the suppression of the individual self. One malady was the disorder and conflict of capitalist industrialisation (Durkheim, 1893). Another was suicide (Hawthorne,1987). Durkheim argued that psychological health, a sense of well being, and by implication a relatively higher protection from stress, are generated in social orders in which there is a balance of both egoism and anomie (individualism) and altruism and fatalism (collectivism), (Taylor and Ashworth, 1987). The parallels with contemporary 'communitarian' ideas are interesting. Chapter 1 describes how, for Etzioni, the balance between individualism and collectivism in modern society has swung too far towards the former, with disorder and social breakdown the result. He wants to see individualism balanced with social responsibility based on restored communities, (Etzioni, 1993).

Durkheim's continuing influence and relevance is evident from recent reports on contemporary suicide rates. A dramatic rise in suicide among young males for example, has been linked to the

isolation and stress associated with unemployment, as well as alcohol, drugs and family breakup, (Smith, 1994). Similarly an increase in the suicide rate in the Highlands of Scotland has been linked to isolation and the decline of the old Highland way of life, (Hennessy, 1994). Recent health research, boosted by epidemiological and psychological work which demonstrates that stress may raise peoples susceptibility to disease in general (Cassel, 1976) has turned to the significance of social ties for physical as well as psychological illness (Morgan, 1985). For example, married male smokers have only a slightly greater chance of dying from heart disease than divorced males who do not smoke (Lynch, 1977). Totman looked at a range of small scale studies on heart disease, cancer, and early death, in which mortality and morbidity were related to such ' life events' as divorce, bereavement and redundancy. He suggested that those most resistant to illness are likely to be socially involved and well adjusted to a stable role within a supportive community, (Totman, 1979). The importance of social ties to health has been demonstrated in official surveys. The 1992 Health Survey for England showed that higher blood pressure was evident in men who were widowed, divorced or separated, and that men and women who were widowed, divorced and separated were more likely to consult their GP than were those not in these categories. (OPCS, 1992).

Theories on anomic suicide can be seen to be influential in those health studies, like Brenner's described in chapter 3, which have looked at the effects of booms and slumps, and unemployment on mortality (Brenner, 1979). Theory on altruistic suicide appears to have less relevance for today's societies in the developed world, but Brown and Harris's study of women in a traditional outer Hebredean society suggested that, while high levels of integration were negatively associated with depression, they were also positively associated with anxiety and related symptoms, (Brown and Harris, 1978). It is theory on anomic and egoistic suicide however, as well as Durkheim's related theories on community and solidarity (described in chapter 2) which appear to have had most influence in those studies which examine the extent of an individual's social ties and community integration and his or her physical or mental health.

Social networks and health

A substantial body of literature has identified the crucial role played by social networks in the health of individuals from a variety of social backgrounds (Blaxter, 1990; Wolf, 1993; Berkman & Breslaw, 1983; House, 1982). For example, respondents in the Almeda County Study who scored low on measures of social contact - extended family and close friends, church membership, and other group affiliation - were found to be more than twice as likely to die in the 9 year follow up

period than those with more extensive contacts (Berkman & Breslaw, 1983). The study ruled out any process of self selection which may have occurred, by demonstrating that the weak social network configurations appeared to precede serious illness. The Health and Lifefstyles Survey (HALS) in this country found a similarly strong relationship between high integration- as measured by household and family situation, frequency of contact with family outside the household and with friends, working status, having children, having surviving parents, whether born in the area, length of residence in the area, attendance at a place of worship, involvement in community work, and whether the individual says that they feel 'part of the community'- and both physical and psychological self assessed health (Blaxter, 1990).

The evidence from large scale studies demonstrates that even after controlling for established risk factors, like behaviour and lifestyle, class and ethnicity, social ties play a crucial role in the individual's health (Lasker et al, 1994; Kaplan et al, 1988; Blaxter, 1990; Berkman and Breslaw, 1983). Blaxter concluded from her research that social support (assumed as the main function of social networks), health related behaviour, and socio- economic circumstances all have an independent effect on self assessed health and all reinforce each other. Even in poor circumstances a combination of healthy behaviour and social support can be protective . Interestingly however, in the absence of social support, little protective effect of behaviour could be discerned, (Blaxter, 1990).

Explanations

Approaches to explaining these relationships tend to fall into three categories. The first concerns the relationship between stress and social ties; the latter are seen as acting either as a buffer against stressful life events or as exerting a more direct influence (Brown and Harris 1978; Lynch, 1977;Cassel 1976). The second concerns the importance of social support as a prime function of social networks. The concept has been used somewhat inconsistently. Is support being measured, or integration? Is support invariably beneficial to health? What is the relationship between network structure and support? (Whelan, 1993;Thoits, 1983;Hall and Wellman, 1985). The third approach concerns values: integration into social networks (rather as Durkheim believed) is seen as providing individuals with a set of values which protect from uncertainty and ill health (Totman, 1979; 1990). Here attention is generally focused on stable communities with traditional value systems. A study into the health of Japanese immigrants in California for example, uncovered much lower rates of heart disease among those who maintained close links with the traditional Japanese community than amongst those who did not (Cassel, 1976; Marmot, 1975). The receipt of traditional values

afforded by membership of a largely Italian community in Roseto, US, was similarly found to protect against heart disease, in this case over a period spanning several decades (Wolf, 1993). Just as there are problems with assumptions made concerning the role of social support in health protection, then there are problems with the role of values. What we could ask, is being measured, social integration or values? Clearly *social integration* is important , but it is not necessarily self evident that integration into traditional *values* is the sole decisive factor. Studies of elderly people in isolated rural communities have explained their longevity in terms of the contribution that the old people were able to make as productive members of their society, (Leaf 1973; Norberg and Hodge, 1992). Being closely integrated into normal economic and social patterns of behaviour, feeling good about it, having some degree of control over their lives and say in the community, might, one could suppose, be important operative factors. Moreover, if values play a key role, which values are protective, and must they be "traditional"? What might be the role of values which challenge orthodoxy?

Network ties and functions of networks

That the extensiveness of social contacts is important for health is clear. At the time the Almeda study (Berkman and Breslaw, 1983) was carried out, it was thought that the mere existence of ties helped health, now researchers see different kinds of relationships as providing different kinds of health promoting support (Walker,M et al, 1994). Others look, not at individual characteristics of network members, but at the characteristics of the network as a whole.

An individual's social network can be seen to be considered from three angles. First, from the point of view of the *characteristics of the people* in that network, such as the type of relationship - family, friends and neighbours. This can also concern such features as age, employment status, ethnicity and class. The second, from the point of view of the *structure* of the network: its extensiveness, patterns of proximity, frequency of contact and density, ie, the degree to which network members know one another. Third, there are the *functions* that networks provide. The functions of networks can themselves vary according to the individuals in the network, and the structure of the network. An important question- given the health advantages bestowed by networks- is why people choose to enter into relationships with some people and not others.

The functional content of relationships includes such things as social support - practical, instrumental or emotional aid, and social companionship (Cohen and Syme, 1985; Oakley 1992). Networks have been shown to confer social esteem (Brown and Harris, 1978), control (Blauner, 1964), and a feeling of belonging (Wellman and Wortley, 1990). A relatively neglected function

concerns positive self identity (Thoits, 1983). For Goffman, a person's self concept is reflected in interaction with others (Goffman, 1959). Major life events, like unemployment, may negatively impact on health because they result in identity change and the undermining of self concept (Swann and Brown, 1990; Kelvin and Jarret 1985;Gaillie 1994). Practical aid is of particular importance when looking at people in deprived circumstances. Supportive networks can help people to cope, for example from long term problems like poverty, as well as from short term crisis, and some may, as Wellman and Wortley suggest, provide social capital to change status - homes, jobs, spouses, or change the world (Wellman and Wortley, 1990).

Types of ties and support

Research has shown that different categories of people- friends, family and neighbours- tend to provide different kinds and degrees of support as well as other advantages. Willmott found that relatives were important sources of support for help with children's illness and babysitting, financial advice and loans, and at critical stages of life. They were particularly important for working class people. Local friends however, particularly those who began as neighbours, were found to play a crucial role in day to day help and support as well as in sociability (Willmott, 1986). Friends generally, appear to be more important than family contacts in protecting against loneliness, and for morale, self esteem and quality of life (Schulz, 1985; Bulmer, 1987). Friendships between elderly women for example enable them to partially compensate for poverty and bereavement (Arber and Ginn, 1991; 1993). Neighbours are important too, especially in the lives of the elderly and for families with dependent children (Willmott, 1986).

Wellman and Wortley evaluated explanations of why different types of ties provide different kinds of supportive resources . One of these is the similarity/dissimilarity explanation. There are two conflicting arguments here. The first is that *similar* persons may be more empathic and supportive - shared interests foster empathetic understandings and support (Wellman and Worltley 1990). An example would be Suitor and Pillener's notion of "homophily", that is, that individuals are more likely to develop social networks with people like themselves, (Suitor and Pillener, 1995). The second is that *dissimilar* persons provide wider access to diverse resources. These arguments reflect Durkheimian and Simmelian conjectures that relationships which cut across social categories foster solidarity and satisfy mutual needs (Wellman and Wortley, 1990; Simmel, 1950; Durkheim, 1893). Granovetter's strength of weak ties is a development of this argument and links to network density. Weak ties, that is loose ties- the persons in an individuals network tend not to know each other- connect socially dissimilar persons and provide greater access to information and

services, (Granovetter, 1973). [2]

Who and how people see others as like themselves could be seen to be crucial here. Similarity explanations of social support have especial relevance to friendship. Abrams noted that people do not always readily distinguish between friends and neighbours, (Abrams, 1986). When does a neighbour become a friend? Pythagoras identified a key component of friendship: *equality.* There are echoes of this notion in contemporary work. For example: "friends tend to share interests and lifestyles, and to exchange assistance as equals" (Arber & Ginn 1991, p 165; Crohan and Antonnucci, 1989); "Friendship is a relationship between equals" (Allan 1979, p. 44). The *content* of friendship is frequently analysed from one of two perspectives: the first seeks out its emotional and affectional qualities, the second views friendship as a system of social exchange. Abrams built on exchange theory to identify both reciprocity and altruism as key features of informal befriending. In the case of the formal neighbourhood care schemes he studied, a perceived lack of social distance between helper and client was a central feature of successful schemes. Where this did not occur, participants felt able "to bridge the distance between themselves and others by the belief that common membership of a moral community, typically a church, legitimates intrusion" (Abrams 1986, p.114). There are at least two problems here, both impinging on individual freedom and autonomy. One concerns the possible imposition of support on those who may resent it, the other concerns the imposition altruism places on *women* who have been traditionally expected to provide it. For Gans, however, perceived homogeneity, the propensity to see other people as like oneself is an essential requirement of positive neighbouring (Gans, 1961).[3]

Network Structure

The importance of the extensiveness of networks to health is clear from the literature on social ties and health. The relationship between health and network density- or the degree to which persons

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[2] Wellman's research in East York, Toronto, operationalised similarity and dissimilarity, by looking at educational level, employment status. gender, age, and marital status.He found only age dissimilarity and employment similarity to be strongly correlated with provision of support. Network members with similar employment status were found to be more likely to exchange small services than those with different employment status and younger adults were more likely to provide older ones with physical labour and older ones provide knowledge and impart skill. In addition, he noted that women homeworkers help each other, (Wellman, 1979).

[3] How others perceive us may also be important here. Swann and Brown argue that both emotional support and positive life events are only beneficial for health and wellbeing if they are compatible with self views, and that people strive to enter and maintain relationships with others who see them as they see themselves, (Swann and Brown,1990).

in an individual's networks know each other- is less clear.

For Lockwood, closely- knit networks emphasizing mutual aid were the hallmarks of the traditional working class community (Lockwood, 1966). Bott argued that it is only in the working class that we are likely to find a combination of factors operating together to produce a high degree of connectedness. These include similar occupations, living in the same area, low turnover of jobs and homes, little demand for physical mobility, and little opportunity for social mobility. She recognised however that not all working class families will have close knit networks (Bott, 1957). A key point concerns the relationship between network structure and restricted opportunities: networks are more likely to be close knit if members do not have many opportunities to form new relationships with persons unknown to the other members of the network, and are more likely to be loose knit if they do, (Bott, 1957, p 105; Fischer 1982; Willmott 1987). Density can also vary by age and gender. Willmott's research on friendship networks demonstrated that people in younger age groups reported that most of their relatives knew most of their friends, and that women had more loose knit friendship networks than men, as did people with higher levels of education, (Willmott, 1986).

These studies indicate a relationship between socio-economic characteristics and network structure, and type of area of residence and network structure, but what relevance does network density have to health inequalities? Distributional issues may be significant for example. The network, asserts Pearlin, is a valuable concept because it draws attention to institutional and organisational resources: "And just as the distribution of wealth, power and status are unequally distributed in societies, the extensiveness and resourcefulness of their networks are unequally distributed too." (Pearlin, 1985, p 44-45).

The sociological interest in network density (the degree to which a person's friends know each other) can be traced to a concern with a perceived breakdown of "community" in industrial society. As we have seen, Durkheim argued that mass urbanisation disrupted community ties, eventually leading to individual anomie and depression (Durkheim 1897). Do "dense" networks then, make for "healthy networks", and healthy and cohesive communities? .

Varying degrees of network density do appear to be helpful in different circumstances. In summary the literature [4] indicates that research suggests that networks of high density and strong ties may be helpful for:

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[4]See especially Hirsch, 1990.

i) maintaining social identity and hence well being

ii) conserving and controlling existing resources efficiently in conditions of scarcity

iii) stimulating the Gemeinschaft of the past, in which stable community norms and shared emotional support among a tightly knit group contribute to a general sense of well being

iv) promoting traditional values or the adoption of shared goals

v) promoting increased exposure to "positive" life events

vi) fostering a sense of connectedness and integration

Networks of low density and weak ties are advantageous for:

i) facilitating change in social roles

ii) effective job search

iii) accessing new and more varied resources

iv) promoting better mental health

v) facilitating involvement and satisfaction with new roles

vi) the expression of a wider array of interests and values

(Hirsch 1990;Hirsch 1980;Walker 1985; House and Kahn 1985;Bulmer 1987;Stack 1974; Hall & Wellman 1985; Wellman 1981; Kadushin 1982;Wilcox 1981; Granovetter 1973;Bott 1957).

Taken together, research appears suggestive that dense network patterns may well serve best the stable traditional communities more characteristic of the past, whilst looser systems may be more beneficial in situations of social and economic change associated with today's inner cities. This would need to be investigated. It may well be however, as Hirsch et al have suggested, that a lower density network overall with several dense clusters most effectively promotes personal growth and enhances adaptation without sacrificing a sense of community (Hirsch et al, 1990).

Local networks

Can we assume that *local* ties and networks are important to people? Despite the tendency for many features of modern life acting to weaken the importance of local social ties, the social contacts of many of those in the most deprived groups - the unemployed, working class, low paid, pensioners, lone parents , as well as mothers with young children, are likely to be relatively restricted to the local area (Bulmer 1987; 1986) ;Willmott 1987; 1986; England,1991). Research has shown that the childless elderly for example, have social networks which are strongly located in their neighbourhoods (Broese Van Groenou, 1995). Friendships between working class people have, in the case of men, tended to be restricted to particular contexts, such as work, sport, or the pub,

(Allan, 1979). If this is so, then aspects of social change, particularly unemployment and cuts to services may be acting to restrict the range of contexts in which friendships can form. The importance of the local arena then becomes particularly significant.

MECHANISMS

Some of the benefits to health and well being of social networks have already been briefly examined. As we saw in chapter 3, poverty, deprivation and unemployment continue to have a marked effect on psychological and physical health. A number of explanations have been put forward on the mechanisms involved. [5] Research which has focused on the mechanisms involved in the relationship between unemployment and ill health is of particular interest, especially where there is emphasis on the effects of both material and social deprivation. Studies considered here have examined the role of stress, insecurity, financial problems, and social networks (Bartley 1994;Brenner 1979; Eyer 1977 a&b; Gaillie et al 1994; Burchell 1994; Cassel 1976). Some studies link the financial problems associated with unemployment directly to ill health (Bartley 1994). Change in family income as a result of unemployment has been found to lead to worse psychological health (Jackson 1984;Bartley 1994). Long term unemployed who had to borrow money have been found to have more than double the risk of depression- as measured by the GHQ- than those who did not have to borrow, and were also more likely to suffer a deterioration in physical health (White 1991;Bartley, 1994).

Brenner's explanation for excess deaths from heart disease and alcohol related disorders two to three years after unemployment was at its highest lies in the stress experienced by those who are most vulnerable to recession, ie, unskilled and semiskilled workers. Research undertaken as part of the Social Change and Economic Life Initiative suggests that insecurity is also a highly important causative mechanism in generating psychological stress (Burchell, 1994). Using the General Health Questionnaire (GHQ) score [6] as a measure of psychological stress, he found no significant difference between the level of stress among the unemployed and among a highly insecure category of the employed- people who had experienced past downward mobility, past unemployment and

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5 Commenting on evidence of a widening of mortality differentials between deprived and better off areas since 1985, Dorling suggests that "many of the trends ...have occurred too quickly...to be ascribed simply to changing socio-economic structures, or changing causes of death, or simply the reflection of past health variations. Explaining the pattern of life chances will be far more difficult than describing them "(Dorling, 1997, p.47).

6 For a description of the GHQ see for example Bowling, (1991).

low current job security. The pattern for women was different - it was getting a job which made a major difference, not the security of the job. The effects of insecurity were not however, limited to psychological health, but were found by researchers on this series of studies to have consequences for marital dissolution, (Lampard, 1994).

Eyer however, in a series of classic articles, takes an oppositional view on the roles of work and non work. (Eyer, 1977, a & b). Eyer is concerned less with conditions of work, and more with the social stresses associated with it. A dismissive passage in the Black report was illustrative of a not uncommon reaction to his ideas: "In periods of high unemployment this [the fall in death rates] is supposed to be the combined result of weakened institutional pressures to consume, relief of workers from stressful work routines, an increase of social solidarity (unlikely as this may seem), the added stimulation of supportive relationships and networks and in general a more varied and more elevated meaning for human existence" (Black, 1980, p. 118).

Social networks have been seen to be protective in other circumstances. Studies on unemployment and health sometimes discuss the likely health effects of unemployment as a feature of social and economic change.[7] In an influential article, Cassel argued that the health of populations is most vulnerable in times of rapid social change. Change itself he argues, may be sufficiently stressful to create an increase in vulnerability to disease. The approach is not dissimilar to Durkheim's ideas on anomic suicide. Cassel suggests that when individuals are unfamiliar with the cues and expectations of the society in which they live, they will be more susceptible to disease than those for whom a situation is familiar. He also suggests that strong social supports can act as a buffer (Cassel, 1976).

The relationship between women's employment status and health may be less affected by insecurity than by certain mediating factors. Using data from the Health and Lifestyles Survey (Blaxter, 1990), Bartley Popay and Plewis (Bartley et al, 1992) investigated the relationship between paid work and health, and domestic conditions and health. They discovered that domestic conditions appear to have an effect on women's health equal to or greater than employment status. Self reported symptoms of ill health increase as domestic conditions - number of children, housing conditions, presence of elderly in the home, children under 3, become more disadvantageous. The effects of domestic conditions on health are of comparable magnitude to that of the woman' s own occupational class. Although being a housewife is not associated with ill health for women in social

[7]See for example Phillimore and Morris, (1991).

class 1, women in manual occupations are least healthy when doing no paid work, and healthiest when working part time. The benefits however of part time work were largely psychological rather than physical. Improved psychological health may be paid for they conclude by more physical stress and ill health.

Recent work has looked not to the detrimental effects of unemployment, but to the benefits to health of work itself. Some of this is concerned with issues other than financial benefits, such as the kind of work done, how satisfying it is, how secure it is , and on the degree of control afforded by the work.

Graetz' investigation of the consequences of unemployment on the psychological health and well being of young people showed that '..the psychological benefits of employment are not delivered across the board, but are confined to those who are satisfied with their work. For those who are dissatisfied, any potential benefits are cancelled out"(Graetz 1993, p.723). Unsatisfying work was found to be the most potent source of health disorder. Although unemployment itself had adverse health consequences, they were confined to those who were satisfied with their former jobs, (Graetz 1993 p.722).

It is not clear from this what it is about work which is either satisfying or unsatisfying, although evidence discussed earlier would suggest job security or insecurity will be a factor. Researchers have suggested that work *in general* , can have a beneficial effect on health because it can raise self esteem and can confer power (Rosenfield, 1989; Thoits, 1982) and can protect from the depressive effect of life events like divorce, bereavement, moving home etc, especially in the case of working class women with young children (Brown and Harris, 1978). It has been suggested that paid employment may be beneficial by increasing the scope of the individual's personal control, but that it is the additional control given by *higher income* which was important, not the performance of an occupational role (Bartley, 1992).

Jahoda suggested that employment fulfills a number of vital latent functions. It provides an enforced pattern of activities and gives people a clear time structure to the day; it is a source of social contacts outside the household; it gives people a sense of participation in a wider collective purpose; and is a source of social status and identity (Jahoda, 1982). Social psychologists have suggested that unemployment affects identity, leading to increased self consciousness, the undermining of people's self concept, and the return to a state of psychological dependence on others (Gaillie et al, 1994). Gershuny's evidence as part of the Social Change and Economic Life Initiative reveals a

relationship between the degree of access to certain of Jahoda's experiences and psychological health (Gershuny, 1994) but its effects are very marginal for women (Gaillie et al, 1994 pl8). A problem with the Jahoda thesis, according to Gaillie, is that it does not address the issue of whether or not there is a difference between men's and women's experiences (Gaillie et al, 1994).

What is striking about much of the work discussed above, is the similarity between the identified benefits of work and the benefits of social networks. Gershuny examined the extent to which out of work activities of the unemployed may compensate for the psychological effects of employment loss. Activities outside employment can, he suggested, especially for the more active and social, provide to some degree experiences of the type that Jahoda has seen as vital for psychological health, but they would not appear to be a satisfactory substitute for employment itself (Gershuny, 1994).

Social networks can be seen to play a crucial role in mediating between an individual's employment status and their health status. Gaillie et al (1994) suggest that the *effects of unemployment are highly mediated by the social location of the individuals who experience it.* Unemployment was associated with a particularly low level of sociability among single people for example (Gaillie 1994 b; Gaillie et al., 1994 p. 252). An indication of the relative inadequacy of the support networks of the unemployed in relation to health and general dissatisfaction with life is provided by Ratcliffe and Boglan. The women in their study most dissatisfied with their unemployed state were those who found themselves in a contradictory situation, that is, they held a personal commitment to women's work outside the home, but the attitudes of those in their social networks were negative. Their findings suggest that "while some unemployed women suffer from a lack of close friends, a more common pattern may be for a woman to be surrounded by "caring others" who may undermine her by denying the legitimacy of an activity she regards as important" (Ratcliffe and Boglan, 1988, p. 54).

Relatively impoverished social ties are not confined to the unemployed. Social and material deprivation are, of course, as we saw in chapter 3, interlinked. Social deprivation for Townsend, is a function of poverty (Townsend 1987). Financial problems are said to be at the root of growing inactivity and social isolation of the unemployed (Bradshaw et al 1983; Clarke, 1978; Bartley, 1994). Interviews from Cohen's 'Hardship Britain ' study reinforce the evidence from studies which indicate clear links between unemployment or poverty, and restricted social activities. In these cases the relationship appeared causal: lack of money led to restricted social interaction, (Cohen et al, 1992).

Many of the studies described here on the mechanisms involved in the relationship between work and non work and health were based on large scale surveys, including secondary analysis of large scale data sets. Qualitative studies on the effects of poverty in general which report on the experiences and feelings of those who experience it can, and have, added to knowledge of factors which mediate disadvantage and ill health. These factors include, stress and anxiety, behaviours, low self esteem, control, stigma, lack of hope, as well as social networks and relationships, local facilities, and coping with material deprivation and hardship. Many of these have also been linked to negative health outcomes in the health literature.

The strains and stresses involved in coping on a low income are well documented . Income support claimants interviewed for 'Hardship Britain ' for example, reported that they were regularly cutting back on basics like food and heating. Ill health was found to be prevalent and lack of money makes it difficult for people to cover health related expenses, (Cohen et al, 1992, p. 11). Some of the low income families with debts living in inner city districts interviewed by Kempson, Bryson and Rowlingson, experienced relationship difficulties, anxiety, and health problems, as well as fuel disconnections , court proceedings and even prison (Kempson et al, 1994). Graham noted that recent studies have drawn attention to the toll that debt takes on mental health: "Knowing you cannot make ends meet and have to borrow to survive brings with it a particularly acute kind of anxiety ...stigma...shame...embarrassment that relatives and friends find out" (Graham, 1993, p. 147). Avoiding debt may also be harmful to health. Kempson et al found that some families avoided debt by very careful management, but at substantial cost in stress and ill health. Mothers for example, sacrificed their own diet for their children. A study by Lea and Gibney, mentioned by Graham, demonstrated that mothers, especially lone mothers, were not getting the recommended daily nutritional levels which they needed (Lee and Gibney, 1989). Other factors apart from money have been found to affect the overall quality of life experienced by poor families; these included inadequate housing and a lack of local services, (Cohen et al, 1992).

Stress has been generally identified as a major mechanism by which problems, difficulties, lead to physical and mental illness, (Cassel, 1976; Brenner 1979; Totman, 1990). Just under half of the parents interviewed in Bradford for Cohen et al's study said that money problems led to anxiety which then affected their health. Headaches and loss of weight were frequently mentioned and related by residents to stress. However, the effects of stress may not be universal. Cassel has argued that it is the strength of the social supports provided by the primary groups of most importance to the individual which act as the most important protective factors buffering or cushioning the

individual from the consequences of stress. He argues that it is important to strengthen the social supports available to people (Cassel 1976). Practical help from friends and relatives can certainly do much to ease financial problems. Studies have shown that Grandmothers, for example, will often buy clothes and shoes for children (Graham, 1993).

To cope with poverty and deprivation, people may turn to smoking. Smoking has been identified as the single most significant cause of ill health and premature death, (Graham 1993;Department of Health, 1992) Graham's survey of 900 young mothers caring for young children in manual working class households indicated that 68% of those dependent on income support were cigarette smokers (Graham, 1993). As Graham argues, personal coping strategies can also be health threatening. The processes involved in health threatening behaviours are complex, and have been linked to both structure and attitudes. It has been argued for example that "Smoking itself cannot be disentangled from the complex of cumulative influences in which the main determinant is social structure: thus smoking becomes part of a causal pathway and not the sole explanatory variable..." (Spencer, 1996,p. 175) . Marsh and Mackay suggest that giving up smoking is easier when your self esteem is high, you feel optimistic about life and you feel in control (Marsh and MacKay, 1994).

Brown and Harris identified self esteem as an important mechanism involved in protecting health. Their study of working class women in Camberwell examined the effect of distressing or disruptive life events, such as bereavement, job loss, widowhood, and moving home, as well as longer term difficulties like poverty, in relation to certain "vulnerability factors". The death of a mother before 14; the absence of a close and confiding relationship - especially with a husband or boyfriend; the lack of a paid job and the presence of three or more dependent children in the home all made women more vulnerable to depressive illness, but only when triggered by disruptive and distressing life events. The presence or otherwise of vulnerability factors is seen by Brown and Harris to affect the ability of the individual to cope and therefore to protect their health. Class related differences in depressive illness are explained not only by an increased preponderance of working class women to suffer from disruptive life events but also by the higher incidence of vulnerability factors among them (Brown and Harris, 1978).

Lack of self-esteem is judged by Brown and Harris to be the common feature and function of all four vulnerability factors. Self esteem they describe as the ability to hold good thoughts about ourselves and confidence, and as "a sense of one's ability to control the world" and thus repair the damage caused by life's problems (Brown and Harris, 1978,p.235). Gerhardt has criticised the use

of 'self esteem' as an explanatory concept, preferring an explanation which gives the relative lack of economic resources among working class women a prominent place in determining ability to cope (Gerhardt, 1979). Qualitative studies on poverty including 'Hardship Britain' have illustrated the way in which living in poverty can damage self esteem. Some people, especially women, felt guilty, for example, that, because they could not provide for their children as they wished to, they were not being good parents, they were failing as parents (Cohen et al, 1992). There are other ways in which self esteem can be damaged. Many of those on benefit in Cohen's study shared the common perception that they are of less value than others in society. In addition, many of the claimants expressed feelings of stigma derived from their experience of the social security system, feelings which had become more or less internalised.

The experience of poverty is frequently expressed as a feeling of powerlessness, a lack of hope, or a loss of faith in ourselves and others (Faith in the City 1985; Cohen, 1992;Golding, 1986;Seabrook, 1992; 1985). Not surprisingly, perceptions of lack of control, hopelessness, and of fatalism, as well as poor coping mechanisms, have been related to negative health outcomes (North, 1993;Kaplan, 1991;Taylor,1991;Schultz, 1991; Greenberger, 1991;Wheaton, 1982; Brown and Harris, 1978).

Research has demonstrated the importance of control, particularly perceptions of personal control, to both physical and psychological health. Studies in the work place for example have identified the negative effects of perceived lack of control on health, (Karasek and Theorell, 1990; Wilkinson, 1996; Greenberger, 1991). Wedderburn and Compton's classic study on machine shop workers found higher rates of "absenteeism" amongst these workers subject to tight control by supervisors, than amongst others with more control over their work (Wedderburn and Compton, 1972). One of the key findings of the Second Whitehall Study on civil servants was that "Men and women who rated their jobs as low for control, variety and use of skills, pace, support at work, or satisfaction had higher rates of short and long spells of sickness absence compared with those who rated their jobs high for these characteristics" (North et al, 1993,p.363). Health studies have shown the better health outcomes of patients who were involved in decision making about their treatment, and the importance of control over ones life in coping with illness (Kaplan, 1991; Taylor, 1991;Schultz and Brenner, 1977).

The links between psychological health and perceptions of control are well established. For psychologists, the learned helplessness model of depression holds that a critical cause of depressive symptoms is the belief that the outcome of one's actions are uncontrollable, (Rosenfield 1989). Similarly, locus of control formulations hold that beliefs in external control, such as luck, or fate

are related to anxious and depressive symptomology. Women generally perceive themselves to have lower levels of personal control than men, and this, argues Rosenfield, helps to explain sex differences in anxiety and depression (Rosenfield, 1989). For Wheaton, perceptions of control are class linked. Low socio-economic status in either childhood or adult life, he argues, will socialise individuals to be more fatalistic in their causal perceptions: " Fatalism will increase one's vulnerability to psychiatric disorder primarily because it undermines persistence and effort in coping situations", (Wheaton, 1980 p. 101). .Socialisation encourages low status individuals to believe that they are less successful than the norm, and that they have little personal power. In addition, he argues that stressful life change events undermine the individual's personal sense of personal power and control, which in turn, may lead to giving up, (Wheaton, 1980). An alternative view might be however that people's perceptions of powerlessness may be real enough. "Giving up" may be a realistic response to the circumstances they find themselves in. In reality, power and other resources are inequitably distributed in society. Despite wanting to change their situation, many people, as studies including Cohen et al have illustrated, feel trapped and powerless to improve life for themselves and their families. This results in considerable emotional stress (Cohen, 1992).

Perceptions of empowerment have been linked to resources. Hobfall builds on the view that mental health is largely the product of being empowered, and that resources are the basis of empowerment. He links resources to social networks however, and argues that emotional support and personal resources are more crucial for well being and the feeling of empowerment for both provider and recipient than is the possession of instrumental resources, (Hobfall, 1990). Classic work based studies have also linked social networks to perceptions of control. Blauner, for example, noted that those workers who feel the least control over their work are assembly line workers. They experience isolation, work as individuals, and have little opportunity to socialise in groups (Blauner, 1964).

A lack of hope characterises today's inner city areas [8] and has been linked to negative health outcomes (Wheaton, 1980;Brown and Harris, 1978) Hope and a fighting spirit have been found to help cancer patients (Watts, 1996). Links between hoping and coping have been noted by Graham: "As mothers try to hope, they also find ways of keeping going. They develop routines and resources which help them face each day. They must enable mothers both to maintain their health

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[8] See for example Faith In the City 1985 .

keeping and house keeping responsibilities and to find some respite from them" (Graham, 1993, p. 177).

The studies already discussed have identified the effects of poverty, many of which have been shown to be health damaging. Though there are indications that social networks can offset health damaging effects, the majority of studies (Brown and Harris and Whelan are exceptions) do not systematically look at the health benefits of networks to poor people specifically. However, a number of studies have investigated the benefits to health of various kinds of social interaction as well as the mechanisms involved for people in general, poor and non poor alike. Participation in informal and formal organisations has been found to be beneficial to health. Churches for example, as well as providing formal and informal care, encourage social interaction and friendship. It is through mechanism such as these, that church attendance is thought to increase longevity, (Angel et al, 1992; Rogers, 1996) .

Participation in other organisations, including voluntary work, is also related to better health and longevity. The important mechanisms here have been recognised as the provision of social involvement and recognition, social support, and a means of fulfilling a sense of civic responsibility (Moen et al, 1992; Rogers, 1996). Putnam contrasted Italian regions which had high with those which had low levels of civic community - what we might loosely call participation- as measured by the proportion of the population voting in referenda, newspaper readership, and the number of associations for voluntary, cultural and sporting activities per head of population- and found evidence of lower infant mortality in the former. Wilkinson looked at the same data and found statistically significant relationships between these measures of civic community and female life expectancy, (Putnam et al, 1993; Wilkinson, 1996).

Social activities are also health promoting. House, Robbins and Metzner demonstrated that active and social leisure activities- attending entertainments as well as visiting friends and relatives and church attendance- reduce mortality. Passive leisure pursuits- such as watching TV, did not have this protective effect (House et al, 1982). Local leisure and entertainment opportunities are clearly important. Egolf has suggested that these can focus an area's identity, ignite community spirit, and infuse individuals with a sense of belonging to a community or area (Rogers, 1996).

This chapter, in looking at the relationship between social networks and health, and the characteristics, structures and functions of networks, raises some questions:

What influences network formation? Why do people enter into relationships with some

people and not others?

Does network structure make a difference to health?

Do different kinds of networks (according to the characteristics of the people in the network and the structure of the network) affect health in different ways?

What is the relationship between networks and values and attitudes, including those which are known to have a bearing on health?

The poverty literature has identified some of the effects associated with the experience of poverty and deprivation, including,stress, loss of self esteem, stigma, powerlessness, lack of hope, and has associated such attitudes as fatalism with poverty. Studies have also linked most of these attributes to poor health. A question is, are these universally experienced by poor people ? After all, not all poor or working class people suffer from poor health.

To what extent do social networks, (in particular, different kinds of networks based on structure and characteristics of people in the networks) make a difference to the distribution of these attributes?

Is there a relationship between different kinds of networks and the ways people cope with poverty, deprivation ,life events and health problems?

Is there a relationship between networks and health related behaviours?

Studies have shown that various forms of social participation benefit people's health in general.

What opportunities are there in poor areas for people to participate in this way?

Can activities compensate for the benefits associated with work?

These questions are taken up in the qualitative field work.

5. THEORETICAL PERSPECTIVES AND METHODS OF RESEARCH

THEORETICAL PERSPECTIVE

No one single perspective has been adopted. My approach is informed by current political, policy and sociological approaches to poverty and community. Ideas on social inclusion, stakeholding and communitarianism have been key influences, but so too have ideas associated with certain nineteenth and early twentieth century political thinkers: the co-operative and 'utopian' socialism of Owen, Morris and GDH Cole. (Morris,1879;1890;Owen,1877; Cole, 1919; 1920; 1950). However, a major theoretical influence on the qualitative research is Emile Durkheim. On community, I was influenced in particular by Durkheim's focus on the search for conditions which foster solidarity, and the importance of the role of mediating institutions for organic solidarity. On health, on the conditions which foster a balance between the moral forces- anomie, egoism, altruism and fatalism which he believed were health protecting, and on the importance of social integration for health. Abrams looked for the source of practical altruism in society, particularly in neighbouring, and developed a theory of positive neighbouring based on reciprocity (Bulmer, 1986). Following Durkheim and Weber, he identified four primary directions for morality- custom, altruism, reciprocity and egoism. Good relationships, he believed, held all four in balance.

A basic Durkheimian approach to community and health has been overlaid with an emphasis on the importance of the distribution of resources derived as much from Titmuss and Townsend as Marx, a recognition of the tension between structure and action from both Marx and Weber, and between structure and values from Weber, (Gerth and Mills, 1948). For Marx, for example, man is both a product and a producer of the social relationships of which he forms a part (Giddens, 1971), structure, historical circumstances, and material circumstances act as constraining influences on action. "Men make their own history, but they do not make it just as they please;...but under circumstances directly encountered, given and transmitted from the past." (Marx, 1852, p.360). Giddens' structuration develops classical theory, and stresses the duality of structure and action. Structures make social action possible: at the same time, social action creates those structures It is this duality which allows structures to survive over time (Giddens, 1984). Giddens' theory facilitates the moving away from the determinism (if exaggerated) inherent in Durkheim.

The emphasis on social consciousness in my research is Marxian, and Westergaard is a key influence- in particular his questioning of the idea that the neighbourhood can be a source of solidarity, in the sense that shared interests between unlike individuals and groups are recognised

, and for the idea that vision and hope need to join with solidarity to extend its boundaries. Other than the classics and their descendants, Wilmott's community of attachment is a key concept for looking at social networks, community and solidarity. The concept combines interaction with others with a sense of community and identity; it suggests attachment to people and to a place. One element has to do with the extent and density of social ties, and the other with perceptions, with the extent to which people feel a sense of identity with a place or group and of solidarity with their fellows (Wilmott, 1989).

Additional perspectives which have been influential in helping frame my research questions for the qualitative case study are those of W. J. Wilson, R.K. Merton, and E. Bott. Merton (1957) developed the concept of anomie, or a situation of a disjunction between means and goals. When the realisation of 'societal' goals associated with the American Dream- of achievement, consumption, the good life - are blocked, then this creates feelings of relative deprivation among many unprivileged individuals, who then respond in various ways [1]. Though more relevant to a study of deviance than health, the ideas are nevertheless relevant in this context in that the focus is on action - the response to poverty, deprivation and inequality. If perceptions of inequality are detrimental to health (as Wilkinson has suggested), then how people respond to perceived inequalities is likely to be important also. *Reference groups* are relevant to perceptions of inequality, and the likely effect of such perceptions on health. Merton suggested that individuals see themselves as deprived, or privileged, by comparing their own situation with that of other groups and categories of persons. The extent to which they will see themselves as deprived will vary according to the category or group selected as the basis of comparison.

Bott developed the concept of 'reference group'. For her, it is linked to identity and values, rather than perceptions of deprivation. It refers to any group, real or fictitious, employed by an individual to evaluate his or her position with that of others. S/he may belong to the reference group, or may not. Reference groups may be positive or negative. The individual will adhere to the norms of a positive reference group, but not to a negative reference group. In forming their attitudes and beliefs, and in performing their actions, people will compare or identify themselves with other people, or other groups of people, whose own attitudes, beliefs and actions are taken as appropriate measures (Bott, 1957).

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[1] Individual adaptions include an innovatatory response- keeping goals but rejecting legitimate means; retreatism- rejecting or withdrawing from goals and means; ritualism -slavish adherence to legitimate means; rebellion rejecting both means and goals and substituting new ones, for example, political radicalism.

A recent, and important contribution comes from Wilson. For Wilson, when analysing trends towards the concentration of the poor in ghettos in America, both structure and culture/action are crucial. The loss of work, he believes, has been instrumental in affecting individual attitudes and behaviour (Wilson 1996). His ideas provide a link between structuration theories, and theories on concentration outlined in chapter 2.

Approaches to poverty and social exclusion can, to some extent, also be seen to parallel theoretical tensions between structure/action. Poverty, for Room, refers to a lack of resources, while social exclusion, refers to inadequate social participation, lack of integration, and a lack of power (Room, 1995).

Perspectives influencing my choice of research methods are described below.

Questions based on theoretical perspectives

1. Structure and action

To what extent do structural constraints determine health?

To what extent do structural constraints affect networks ?

What role is played by values, attitudes, action, in both networks and health?

What relevance do reference groups have for the characteristics and qualities of social networks ?

Do social networks provide a link between structure and values?

Is there a relationship between social networks and how people cope and respond to poverty and deprivation ?

2.Networks and communities

Can we identify health promoting networks and health promoting communities?

As mentioned earlier, a problem with Durkehemian approaches to both community and to health is that it is not always clear whether it is the integration of the individual into the community which is being addressed, or the integration or cohesion of the community as a whole. A close examination of social networks may help in understanding the relationship between the two. In health terms, the literature has suggested (Whelan, 1993) that networks may mediate socio-economic position and health, though this aspect of networks is under-researched. A question is whether networks mediate place/community and health also, and in what way. What local features

can act to 'include' people in their local community, and which exclude?

Can we identify characteristics of a) an individual's social networks which are likely to be health promoting and b) characteristics of local communities which can foster health promoting networks?

a) Social networks

Social networks are likely to be most health promoting in cases where the network is able to access a wide range of functions which networks can provide. To do this, the network will a) need to encompass a broad range of persons or groups, and b) have a flexible network structure which is able to access the benefits to health and well being of both 'dense' and 'loose' networks. It is plausible that if people see a broad range of people as being like themselves (Bott's concept of reference group is useful here) then their networks would consist of both dissimilar and similar persons, and the kind of advantages and support associated with each would be available.

What affects the composition of networks? What role do values and attitudes play, including hope, perceptions of inequality, attitudes towards mixing with others? [2]
Do different kinds of networks provide different functions?.
Do different network formations mediate poverty and health in different ways?

b) Local Communities

The literature has suggested that the availability of opportunities to lead a healthy life - in terms of facilities and services- is important in the relationship between place of residence and health. I am suggesting that these will include opportunities to build health promoting networks, networks which foster 'inclusion'.

What will influence these opportunities to build health promoting networks?
What role do facilities and services play- housing, employment and the area's history?
Are there opportunities for informal and formal interaction and participation ?

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2 A visionary ideology may certainly be health promoting. Ideology, Salaman has suggested, is, in part, (following Geertz) an aspect of attempts to "flee anxiety" and insecurity (Salaman 1975; Geertz 1964). An extreme example of the protective effect on health of a shared ideology can be found in the highly deprived, rigidly controlled, self and soul destroying environment of 1930s concentration camps. People who did not possess a coherent set of values disintegrated as autonomous persons. Jehovah's Witnesses and communists had a much better survival rate in Dachau and Buchenwald than other groups (Bettelheim, 1961). A property of the ideology common to both groups is a vision of an alternative society.

Are the latter sustained by supportive and democratic structures ? [3]

What features foster everyday neighbourliness ?
What role do less tangible features play in promoting networks, features like perceptions of community, its reputation, a sense of attachment?
What implications are there for health?

To what extent do local, community features affect network formation, ie the characteristics of the people in the network and the structure of the networks. What are these local features?
To what extent do other factors influence networks, such as personal history ?

Do structural features, like loss of work, affect values and culture? Are there implications for health?

Most of the above questions refer to the qualitative research. Ideas on the distribution of resources are relevant to both the quantitative and qualitative parts of the research however. So are conceptual approaches to poverty.

How helpful are the concepts of ' social exclusion ' and 'concentrated poverty ' for looking at health patterns and experience in poor areas ?

RESEARCH METHODS AND PERSPECTIVES INFLUENCING THEM

The general approach

The approach to health and health determinants is holistic: 'Poor health' is not restricted to an individual illness, disease, or health indicator. Because of the complex nature of the processes involved in health determinants, it has been suggested that future research should explore vulnerability to a range of ill health, rather than specific illness (McIntyre, 1986; Cassell, 1976). In addition, the qualitative research approaches health from a perspective which encompasses 'quality of life' and 'well being' formulations.

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[3] I have suggested elsewhere that democratic and outward linking structures are a feature of positive communities, needed to democratise participation, facilitate the forging of alliances, and to empower the poor. The realisation of re-distributive goals - and therefore a dramatic reduction in inequalities in health - becomes a more realistic and less utopian prospect, (Cattell, 1995).

The general coverage in the literature review reflects the interdisciplinary nature of the health inequalities literature itself. Blume identified three major academic disciplines which have played a central part in investigating health inequalities: social administration/social policy, epidemiology, and sociology (Blume, 1982). In poverty, the major disciplines can be identified as social policy and sociology, in 'community' and social networks and health, social policy, sociology, and, though not rigorously investigated here, social psychology. Social problems do not confine themselves to what C Wright Mills referred to as the curious division of academic departments, (Mills, 1959, p.225).

The three disciplines with an interest in social inequalities in health approach the issue differently, (Blume, 1982). Social administration focuses on unequal provision and take up of services, epidemiology is concerned to explore the aetiology of specific diseases, and sociology focuses on structure and social processes. Blume argues that through a multidisciplinary approach the strengths of each research tradition can be mobilised to more adequately explain the persistence of social inequalities in health. He argues that social administration's traditional concern with justice in the allocation of resources, though still essential, needs to be joined by a focus on effects of a broader range of policies than are traditionally connected with health and disease These would include the effects of policies upon family and community structures, upon the urban environment, upon work, and upon environmental pollution (Blume, 1982). Such a broad brush approach has been adopted throughout my research.

The thesis considers both the individual and the social setting. Researchers have stressed the importance of context in the production of health inequalities (MacIntyre, 1986; Jones and Moon, 1993; Eames, 1993; Phillimore and Morris, 1991; Lasker, 1994; Egolf, 1992). Jones and Moon for example, quoting Dyck argue that methodologically, concepts of health, illness and disease will have to be 'Shaped within historically and place specific sets of relations rather than the 'facts' of positive science' (Dyck, 1992, p. 245). This research explores both the patterning of health inequalities and processes involved via a local case study. The study of 'Roseto'in America, though longitudinal, is a notable example of a study of health patterns in a local, cultural and historical context, and of the combination of quantitative with ethnographic techniques. Here, the importance of traditional Italian values and way of life, together with widespread participation in local organisations in protecting against heart disease was highlighted, (Wolf and Bruhn, 1993; Lasker, 1994; Egolf, 1992). In my own research, time and resources rule out a longitudinal study. However, historical context is not neglected. The literature review includes evidence and discussion of health inequalities in the 1940s, a time when there was evidence of narrowing inequalities, and

the local regional case study considers recent demographic, social, and economic as well as health change as evidenced by Census indicators and other official and health statistics. Because neither poverty, community nor health are static experiences, and because an individual's past experience of poverty and deprivation can , according to Davey Smith et al (1997) have implications for their current state of health, qualitative studies on two housing estates in East London do not neglect aspects of life history, though the primary focus is on present circumstances and attitudes.

The research process

Following the literature review I focused on four related questions:

> *1) How is poverty experienced, what are the effects of poverty, generally on people's lives?*
> *2) What is the role of forms of 'social deprivation' as well as material deprivation in structuring health chances? (Social deprivation is defined as the inability to participate in the normal life of the community, in particular, lack of integration into the community, and a lack of participation in social institutions, (Townsend, 1987.)*
> *3) Can integration into the community and thriving social networks reduce socio-economically related inequalities in health? What do people gain, generally, from participating in community life ?*
> *4) What is community? Which aspects of community are likely to be relevant to health and to living in a disadvantaged area?*

I hoped then to be in a better position to understand some of the mechanisms involved in a) the influence of poverty and deprivation on health, b) the protective influence of social networks on health, and c) the role of factors associated with 'community' in influencing health chances. It was hoped that the approach adopted in the thesis would, as well as investigating processes and mediating factors involved in health determinants, also throw some light on some of the anomalies which emerged from the literature. The populations of some areas, for example, have worse or better health on some measures than their levels of deprivation would suggest; lack of income appears to impact more on the morbidity of the middle aged than it does for younger age groups, for whom lack of social support may be more salient. Health standards are declining for some age groups; gender differences in morbidity are not parallelled by similar mortality differences; city life appears to affect some age groups and occupations more than it does others, the psychological health of young manual women is worse in suburban area than it is in working class areas. A particular focus of this research is on the first, that is, the difference that place can make.

A paper I presented to the BSA Annual Conference in 1995 drew together approaches to community, deprivation, participation, social consciousness, and processes involved in health to construct a working hypothesis. A conception of a 'positive community' for positive health was suggested, characterised by flexible social networks, and attitudes of sociability, co-operation, tolerance, solidarity, utopianism plus supportive and democratic structures. It suggested that how people respond to poverty and deprivation may be crucial for their health and well being, and that responses may themselves be linked to the nature and structure of their social networks (Cattell, 1995).

The research was an iterative process. Through the fieldwork experiences the concept of a 'sustainable community' was developed in which the distribution of resources, services and opportunities played a not unimportant role for positive perceptions of the neighbourhood held by residents, and for local interaction, and, by extension, for improved chances of good health.

Additional topics emerged from further reading of the literature and which I had not fully considered at the outset. The importance of 'place' for both deprivation and health was the most salient of these. Discourse and evidence on the question of whether place can have an independent effect on health and on other poverty related issues seemed highly relevant to the planned area based case study. Current theoretical approaches to poverty, particularly those which focused on spatial and social concentration, were also considered. A linked methodological question related to deprivation indices adopted in area surveys of deprivation and health. Do they accurately reflect conditions of deprivation in a particular area ? Another was a measurement issue. Does the spatial scale adopted for analyses, or different kinds of measures of deprivation make a difference to the results obtained ?

Questions on whether opportunities existed for residents to lead healthy and happy lives in case study areas did emerge as an additional feature of the research. Social networks were a dominant part of the picture, but these in turn were found during fieldwork to be affected by other existing or non existing opportunities. In focusing on networks I had been in danger of minimising the role of poverty and deprivation, and it was important to build these factors into the research. As McIntyre has observed, the tendency to concentrate on factors such as life events or social support can create an assumption that the only contribution that social position may make to health is via stress or exposure to life events, to the neglect of more mundane features of peoples lives, like poverty and unemployment (MacIntyre, 1986). It seemed important therefore, to investigate both structural aspects of poverty and deprivation, and the meanings and experience of poverty. The

statistical analysis of the region investigated the patterning of poverty, deprivation and ill health in the region, while fieldwork looked at the constraints that poverty and living in a deprived area put on people's lives. The qualitative research looked at the influence of features connected with the locality on the establishment of networks and also explored the ways in which social networks helped residents to cope with and respond to poverty and deprivation. The role of social networks remains central to the qualitative research, as the interrelationship between poverty, networks and health remains underexplored in the literature. An important exception demonstrated that 'social support' had its greatest impact on the psychological health of the poorest (Whelan, 1993).

In summation, there are four major strands to this research as a whole: poverty and community; people and places. The research explores the dynamics between them, and how they can interact to affect health. Through studying the interplay of these various factors, I hoped to better understand the mechanisms involved in the social processes in poverty related ill health, and the protective influences of social networks on health, especially for those in the poorest groups. An important strand has been the extent to which place makes a difference - over and above socio economic characteristics of residents: a difference to community life, to coping with poverty, to social networks and to health and well being.

THE LOCAL CASE STUDY

A local and comparative case study was conducted to explore these ideas further. There were three reasons for doing so. A comparative approach based on localities was expected to provide a better understanding of the role of place. Secondly , intensive on the ground qualitative research would enable a better understanding of processes and mechanisms involved in the interrelationship between the major components of the research, that is, poverty, community, social networks and health, in context. Analysis of similarities and differences between areas would enable hypotheses to be tested concerning causality and linkages. The comparative method is generally used to test causality (Hammersley and Atkinson, 1987). Setting the research in context would also facilitate concrete description of the development of typologies and models, a commonly used ethnographic technique, (Hammersley and Atkinson, 1987). Given the complexity of the research subject, model building might be a fruitful way to approach analysis. Thirdly, both quantitative and qualitative methods could be utilised, the one informing the other.

There were two main stages: i) a structural overview of the wider geographical area, 2) a qualitative study of two micro areas.

C. Wright Mills argued that the relation of 'personal troubles' to public issues of social structure was the central feature of social science research (Mills, 1970). Researchers now stress the advantages of studies which combine both quantitative and qualitative methods. The synthesis of both macro and micro approaches to research, and structural and interactionist perspectives are advocated (Silverman 1985) as are empirical studies which combine ethnographic and official statistical data (Bulmer 1984). Indeed, as Bulmer points out, this was precisely what those arch ethnographers, the Chicago School did. Census data were used extensively in the programme of Chicago community studies (Bulmer 1980, pp. 505-23). This research has adopted these approaches.

Bulmer argues that the study of health inequalities based on official statistics for example, has been influential (Bulmer 1980). Recent (if belated) official recognition of 'health variations ' supports the argument. Survey methods may not be enough however, if one wants to explain the relationship between demographic factors and illness without getting lost in what Brown and Harris describe as a morass of inconclusive correlations (Brown and Harris, 1978, p 10-11). Demographic measures need to be combined with the experience of the individual (Brown and Harris,1978). The value of qualitative research in adding to the information gleaned from statistical data on *poverty*, and providing insights into the experience of poverty, is well recognised. Listening to the views of the poor is seen as a political issue as well as a technical one, (Cohen 1992).

(i) The Lea Valley: a structural overview

It was considered necessary to set the case study within a deprived geographical area, so that a) associations between deprivation and health at the borough and Health Authority District level could be identified (or not) using statistics and other data, and b) so that deprived sub areas could be easily identified for the micro studies. Exploratory examination of large scale Census based surveys (Willmott, 1994; Green, 1994; Forrest and Gordon, 1993; Forrest and Gordon, 1995) had indicated that poverty and unemployment had grown in London during the 1980s, and that three East London boroughs had suffered disproportionately. These were Hackney, Newham, and Tower Hamlets, part of the newly designated Lea Valley area, and granted objective 2 status.[4] Three other boroughs made up the region: Waltham Forest, Haringey and Enfield. The Lea Valley Region as

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[4] Parts of the six Lea Valley boroughs have been designated by the European Commission as eligible for support under Objective 2 of the Regulations governing the European Structural Funds.

a whole was selected for the study area, with a view to scaling down as various stages of the case study progressed. An additional reason for focusing on London boroughs had emerged during the literature review, which had indicated that London may be an anomalous case in terms of deprivation (high) and mortality (less high than expected), (Benzeval, 1992; Willmott 1992).

A review of available data on the Region was conducted with the aim of providing a (largely statistical) profile of the wider region in which the local qualitative studies were to be placed. The topics selected for inclusion were felt to be those which could most adequately describe the essential elements of a deprived part of London. The collection of data on demographics, housing, the local economy and patterns of employment and unemployment, as well as wages, poverty and deprivation are topics which, in addition, are all implicated in the literature on social inequalities in health.

A major data source is the 1991 Census of Population. Census Summary tables were utilised as well as secondary sources which are Census based. The latter include statistical tables and analyses for the deprived areas of Great Britain published in the Policy Studies Institute's *Urban Trends 2*; for England in the University of Bristol's *People and Places 1, and People and Places 2*; for Great Britain in the Institute of Employment Research's *The Geography of Poverty and Wealth*; and for London in the Government Office for London's *London Facts and Figures,* the London Research Centre's *London 95*, and their recently published *The Capital Divided.* All seven titles use Census data. Urban Trends, London Facts and Figures, London 95 and the Capital Divided supplement Census data with a range of additional official statistics. Use has also been made of The Department of the Environment's *Index of Local Conditions,* a composite index of deprivation based on Census and other official data.

A complementary and major source used consists of the publications made available by the boroughs themselves. They provide local analyses of official as well as locally collected data and include borough and ward profiles, poverty profiles and reports, community care plans, housing strategy statements, economic profiles, reports and serials, development plans, committee reports, and the annual reports of health authorities, public health departments and the like. Locally produced surveys provide an extremely useful adjunct to analyses of official data and were included where available. Although there are occasional exceptions (like reports to Council Committees) the bulk of the data examined is in published form. One set of unpublished statistical data is used however. A breakdown of low pay within the six boroughs derived from unpublished *New Earning Survey 1995* data was kindly provided by the Low Pay Unit and forms the basis of the section on this topic.

In the early stages of this part of the research, indicators for the six boroughs from the 1991 Census Summary tables were examined along with data from local authority and other bodies. There were problems however. Firstly, summary table data available were insufficiently broad or insufficiently detailed in coverage, and Middlesex was not hooked up to the Census via Manchester University.[5] Secondly, although it provided very welcome detail and elucidation, local authority data was produced in different forms and for different purposes by each local authority. Topics selected for attention were not always consistent between boroughs, and varying degrees of detail were presented. These features of the documents made inter-borough comparisons difficult. Additional sources of data had to be sought. An overall framework was adopted involving secondary analysis of large scale Census based surveys described above. This facilitated more thorough and reliable comparisons to be made between boroughs.

Secondary analysis

Secondary analysis has been defined as "any further analysis of an existing dataset which presents interpretations, conclusions or knowledge additional to, or different from those presented in the first report on the inquiry as a whole and its main results" (Hakim, 1982, p.1). It implies a re-working of data already analysed (Dale, 1988).

Secondary analysis is a particularly useful method of carrying out aspects of the kind of research undertaken here. It is especially useful for area based research, and for studying trends over time, (Hakim, 1987). Its advantages are speed and relatively low costs. The disadvantages are that the scope and depth of the research will be constrained by the material already available (Hakim, 1987). Fortunately, a range of excellent national and London based surveys were available at the time of this research. In a sense, secondary analysis was carried out on documents which, of themselves, were pieces of secondary analysis of official statistics.

Critiques associated with the use of official statistics are well known, if, as Bulmer intimates, overstated (Bulmer, 1980). The range of features to be included will have already been selected by the Department concerned, and the agenda set, (Hindess, 1973; Miles and Irvine, 1979; Governments Statisticians' Collective, 1979; Dale, 1988). There may be other issues which are as valid for an understanding of the region and its people: the lack of a direct question on incomes in the Census is an example. Commenting on the limitations of official statistics, Townsend decries

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5 Small area statistics are now available on CDRom.

the fact that the Government and other bodies rely too heavily "on the distorted information conveyed by a few restricted indicators.. there is little or no routinised information on household living standards, income or wealth; individual states of physical and mental health; the type, range and intensity of immediate social, including family relationships; and the nature and extent of individual work and other activity" (Townsend, 1987, p.88). As Frank Field pointed out recently, there simply are not enough government statistics collected on poverty. It was easier, he suggests, to find out about poverty in the 1890s than it is in the 1990s. The old Poor Law reports routinely collected a great deal of information, including data on diets, (Field, 1996).

Another problem concerns definitions: different sets of statistics, produced by separate Government departments, may use quite distinct ones. A familiar example is the Census of Population's approach to "unemployment" and that of the Employment Department. Estimates of unemployment produced by the Census of Population, the Dept. of Employment, and the Labour Force Survey differ quite markedly. In 1991 Census figures for unemployed women for example were 52% higher than the claimant count figure, but for males Census statistics were only 7% higher, (London Research Centre, 1995b). Moreover, definitions change over time: in the case of unemployment for example, the Government changed the method of counting unemployed people well over 30 times after 1979 (Oppenheim and Harker 1996). Exclusionary features of Department of Employment definitions of unemployment are regularly criticised, particularly in relation to the undercounting of women's and youth unemployment, (Hyman and Price, 1979; LBWF 1993).

How the statistics are collected can also be a problem, particularly for comparative purposes. The Census of Population for example is residents based; the Census of Employment workplace based. Similarly, earnings data presented in the Governments New Earnings Survey are, unlike income statistics collected for the Households Below Average Income series and Low Income Families Statistics, workplace based. A major problem concerning use of official statistics on incomes concerns the lack of data at the local level. National and regional income data is available, but little at the borough level. To circumvent the problem, some evidence was gleaned from local surveys conducted by or for Lea Valley boroughs where these were available, but reliability of such comparative work could not be guaranteed.

There are some additional and specific problems connected with the use of the Census. Under-enumeration can be an issue . More than 1 million people 'disappeared' during the 1991 Census, including up to 30% of young men between 20 and 30 in some inner city areas. The homeless and the unemployed were also under-represented along with people with no educational

qualifications and single person householders (Barnes 1992; Brown, 1995; Forrest and Gordon, 1993). Local investigations have uncovered a shortfall in the 1991 Census of Population of homeless people, refugees, travellers, and young men, especially Bangladeshi men (Elcha, 1994/1995).

An important set of difficulties associated with census data lies in its infrequency. As Green points out, the timing of the decennial surveys could be inappropriate, they may be taken at different points in the economic cycle, or be out of tandem with particularly policy initiatives, (Green, 1994). I found this to be a particular problem at later stages of my research. Housing estates, as a result of policy initiatives such as Housing Action Trusts, or Comprehensive Estates Initiatives may experience rapid change over the space of a few years, not only in the housing stock but in the demographic composition of resident populations. Housing research officers in Hackney for example- a borough which has experienced a great deal of estate based re-generation and movement of population- report that 1991 Census statistics were, by the mid 1990s, hopelessly out of date.

Nevertheless, critiques of the use of official statistics in social science research have, according to Bulmer, not only been influential but to a large part unjustified (Bulmer, 1980). Whatever their faults, official statistics, including the census, are used in decisions made by central and local government in the allocation of resources, and their importance should not be underestimated. Green indicates three key advantages of the census over other possible data sources. The first is its comprehensive coverage compared to other social surveys. The second is the degree of spatial disaggregation available, researchers are able to disaggregate to the ward or Enumeration District level. The third concerns its utility in investigating change over the medium term, although complications can arise with intercensus analysis when questions are omitted or added from one census to the next, or when ward boundaries change (Green, 1994). A question on ethnicity was included in the 1991 Census for the first time, with an apparent consequence that analyses of Census data, such as those produced by local boroughs and Health Authorities, focused on variability of indicators according to ethnicity, and social class was given less prominence than before.

Deprivation and the Census

A major advantage of Census data is that they facilitate geographic comparisons. Analysis of census variables is of considerable utility in informing us about the characteristics of populations and the social and spatial patterning of poverty and deprivation. For these reasons in particular, the census was the major source used in the compilation of the Lea Valley structural analysis.

Though clearly interconnected, poverty and deprivation are not the same thing. For Townsend, "People can be said to be deprived if they lack the material standards of diet, clothing, housing, household facilities, working, environmental and locational conditions and facilities which are ordinarily available in their society, and do not participate in or have access to the forms of employment, occupation, education, recreation and family and social activities and relationships which are commonly experienced or accepted" (Townsend, 1979 p 413). "If they lack or are denied resources to obtain these conditions of life and for this reason are unable to fulfill membership of society they can be said to be in poverty. The first [deprivation] turns on the level of conditions or activities experienced, the second [poverty] on the incomes and other resources directly available", (Townsend, 1987,p.85). He distinguishes between material and social forms of deprivation. The first concerns material facilities or amenities, the second, access to ordinary social customs, activities and relationships.

How useful then are Census data in investigating the three separate approaches to disadvantage outlined above, that is, poverty, material deprivation and social deprivation ? The Census is a rich source for the estimation and mapping of indicators of *material deprivation*, like housing and employment status, but proxy measures must be used for *poverty* itself however, or alternative data found. Davies examined the validity of census indicators as predictors of income and confirmed the importance of car access and tenure: those on the lowest incomes are much less likely to have access to a car and much more likely to live in rented accommodation. Unemployment, economic inactivity, living alone and lone parenthood were also found to be important predictors of low income, (Davies, 1993).

Deprivation indices: objectifying deprivation

Census based surveys utilise variables which relate on the whole to material, not social, deprivation. Combinations of a wide range of census variables have been used by researchers to produce deprivation indices. These are frequently used to facilitate comparisons of areas and to inform the distribution of Government grants. Critics of deprivation indices have accused compilers of poor conceptualisation and arbitrary, pragmatic or unwittingly discriminatory selection of indicators (Morris and Carstairs, 1991). Weighting procedures and methods used to combine the individual variables into an overall measure have also been questioned (Morris and Carstairs, 1991; Townsend, 1987).

It is clearly important that the selection of deprivation indicators do accurately reflect conditions of deprivation in a particular area. It has been argued for example, that the Department of the Environment's widely used (until recently that is) *"Z" scores* of urban deprivation *The All Ages social index* skewed the identification of deprivation towards certain types of locality, (Goodwin, 1995). Inner London Boroughs scored heavily on indicators of overcrowding, lack of household amenities, single parents and ethnic origin, while northern cities and outer urban estates are ranked as more heavily deprived on the indicators of unemployment and mortality. Overall, it has been suggested, the result is to exaggerate the extent of deprivation in some cities (notably London) and to underestimate it elsewhere (Goodwin, 1995; Townsend, 1987).

Another widely used deprivation index is the *Jarman Underprivileged Area Score.* The Jarman Index was developed from a survey of 1 in 10 British General Practitioners who were asked to weight social factors according to how much they thought they increased workload. Census data are used to derive scores for wards or Enumeration Districts and extra money is provided for practices with a higher proportion of relevant factors (Elcha, 1994/1995). The volleys of criticism directed towards the Jarman index have been particularly severe. According to Jones and Moon : "the index has become a victim of inflated beliefs in its own effectiveness, it suffers from poor validity, a convoluted statistical basis and simplistic integration" as well as proven partiality towards London. (Jones and Moon, 1993, p. 516). Despite these and other criticisms, a *British Medical Journal* leader expressed the view that basing deprivation payments on the index is still the best option (Hobbs, 1993). Moreover, Jarman scores continue to be correlated with ill health (Payne, 1993) and the relationship between deprivation and ill health is well established.

In response to criticisms concerning the alleged unreliability of deprivation indices Morris and Carstairs examined relationships between five such indices and their utility in explaining variations in health measures (Morris and Carstairs, 1991). Those examined were:

> SCOTDEP developed by Carstairs and Morris for analysis of Scottish health data
> TOWN used by Townsend et al in a number of surveys on deprivation and ill health including the Northern Region and London studies mentioned in chapter 3.
> JAR Jarman and associates developed this measure in relation to need for primary care services.
> DOE Dept of Environment "Z" score measure developed mainly in relation to urban policies.
> SDD Scottish Development Department measure developed mainly in relation to urban polices.

Only one variable -unemployment- appears on each index, with overcrowding appearing on four. Variations of low social class appear on three lists, as do single parent families. Only SCOTDEP

and TOWN include "no car" (widely used as a surrogate for low income) and only TOWN includes tenure. Tenure can be used as a rough approximation of social class, but may have less validity in Scotland where a much higher proportion of the housing stock is in the public sector. Morris and Carstairs found a high degree of inter- correlation between the deprivation measures.

Morris and Carstairs used six sets of health measures- SMR 0-64; SMR 65+; permanent sickness; temporary sickness; standardised bed-days ratios (from hospital discharge records), standardised discharge ratios; standardized mean stay, and correlated these with the deprivation indices and individual measures. The strongest association with health were found for those variables highly associated with SCOTDEP, that is no car, unemployment, and overcrowding, and social class measures. The single variable no car gave consistently strong correlations across the range of health indicators. Townsend's Northern region research similarly stressed the importance of the no car access variable in the relationship between deprivation indicators and ill health (Townsend et al, 1988). Variables showing moderate association with health are those relating to single parents, tenure, the level and access to the dwelling in households with young children, and large households. For my research, the distribution of all but one of the variables implicated in ill health by Morris and Carstairs was mapped for the Lea Valley. The exception was the variable relating to access to the dwelling in households where there are young children, The Index of Local Condition's 'children in unsuitable accommodation' was used instead.

Perhaps the most serious of the various critiques touched on here concern the ways in which deprivation has been conceptualised. Commenting on the tendency for some composite measures (like the DOE "Z" scores and the Jarman index) to include variables relating to *groups of people* Townsend reminds us that "it is important to distinguish between the measurement of deprivation in different areas and the kind of people experiencing that deprivation. Otherwise there is a danger of treating age, ethnicity and single parenthood as causes of the phenomenon under study. It is wrong in principle to treat being black or old and alone or a single parent as part of the definition of deprivation. Even if many such people are deprived it is their deprivation and not their status which has to be measured. And many people having that status are demonstrably not deprived" (Townsend, 1987, p.89; Townsend et al, 1988).

The DOE's *new* deprivation index the " *Index of Local Conditions*" has responded to this and other critical commentary, which includes a concern that the Local Authority districts used as units of analysis are too mixed and large to be viable. Unlike the previous DOE index the "Z" scores or "All Ages Social Index" variables relating to population groups have been omitted. "There are no

indicators measuring population groups at risk of deprivation (eg ethnic minorities, single parent families), whose members may or may not actually be deprived. Deprived members of these groups should already be identified by the more direct measures, such as unemployment or those receiving Income support." (DOE, 1994). [6] The index includes six indicators at the Enumeration District scale, seven at the ward scale and 13 at the Local Authority District scale. The Index of Local Conditions was one of the sources used in compiling the Lea Valley structural overview.

Deprivation and geographic areas

Because later stages of the literature review indicated the importance of spatial considerations when analysing data on deprivation and health , local data were analysed to take some of the issues raised into account. Three approaches were adopted:

1) Concern is sometimes expressed that the Local Authority Districts used as units of analysis are too mixed and too large to be meaningful. Intra borough differences are lost at a district level. (DOE, 1994). One way of circumventing the problem is to take a smaller geographical area as a spatial base. To illustrate variation, the distribution of deprivation is mapped for wards across the Lea Valley region. Another approach is to adopt alternatives to the degree measure (or the proportion of an indicator found in a borough). The Index of Local Conditions uses three measures of deprivation for local authority districts. This is considered necessary because "Two Local Authorities may appear to have very similar overall levels of deprivation, but in practice one may have deprived people or households spread evenly across its area, while in the other they are concentrated into a few neighbourhoods." (DOE, 1994 p. 4). The three measures are:

1. *the degree* or value throughout a borough;
1I. *the extent* or proportion of enumeration districts in any borough which fall within the most deprived 7 per cent of enumeration districts in England;
111.*the intensity* or severity of deprivation, that is , the average score of the worst three wards.

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[6] This is because data for some indicators are either not available or not robust at the smaller scales. All the 6/7 indicators included at the ED/ward scales are from 1991 census data, but the further 6 added at LA district scale are from other data sources and cover aspects of deprivation not adequately measured in the census (DOE, 1994 p.3). The indicators are at all 3 scales: i) unemployment; ii) children in low earning households; iii) overcrowded housing; iv) housing lacking basic amenities; v) households with no car; vi) children in "unsuitable" accommodation. Added at the ward and LA District level are: vii) educational participation (at age 17), and added at the LA District scale: viii) ratio of long-term to all unemployed; ix) Income Support recipients; x) low educational (GCSE) attainment; xi) standardised mortality rates (health);xii) derelict land; and xiii) house contents insurance premiums (a crime proxy) (DOE, 1994). Components are weighted equally.(DOE, 1994).

The deprivation scores on each of the three measures were examined and compared for Lea Valley boroughs.

2) To consider the meanings that different deprivation indicators might have for different areas, local boroughs position on different deprivation indices were analysed and discussed.

3) Few measures were found to be available which could help in an understanding of the relevance of contemporary concepts of 'concentrated poverty'. However, Green's measure of 'isolation' or the extent to which sub group members are exposed only to one another was relevant (Green, 1994). Green's data were examined for local boroughs where data was available on this measure, and the usefulness of this and other measures examined (above) discussed in terms of deprivation in the Lea Valley.

Health

The Lea Valley profile confirmed that the three most deprived boroughs in England- Tower Hamlets, Hackney, and Newham- were located in the Lea Valley region. These are all inner London boroughs. One of the outer London boroughs adjacent to the other three, Waltham Forest, evidenced high levels of deprivation in its southern half. Collection and analysis of health data were restricted to these four boroughs, as was work on policy responses on health and deprivation. The three East London boroughs are located in the East London City and Hackney Health Authority (ELCHA), and Waltham Forest in Redbridge and Waltham Forest Health Authority (R&WFHA).

The approach to collecting and analysing health data was similar to that described for demographics and poverty and deprivation, and incorporated secondary analysis of published documents, but much less reliance was placed on the Census of Population. The Census carries only one health variable- Long Term Limiting Illness. Official statistics on mortality, as well as locally collected data on hospital admissions and consultation rates were examined, as well as self report surveys where available. To access data, reports produced by the two local health authorities were examined for the years 1994/95. Statistics have been supplemented by those presented by the London Research Centre in *The Capital Divided*, and *London 95* and by Wilmott's *Urban Trends 2*, as well as by local authority reports. Statistics have been presented for individual boroughs where available, and for Health Authority districts as a whole where not. In the case of R and WFHA, District figures have been avoided as they include data for Redbridge- a comparatively less deprived area. Their inclusion would have made District wide comparisons unhelpful.

There are problems associated with nearly all available health measures, of both the quantitative and qualitative kind. The use of mortality statistics in relation to class based health inequalities was discussed in chapter 3. Area based Standardised Mortality Ratios were incorporated into the analysis on the four boroughs, however, as they provide a useful and reliable means of comparing boroughs. There are problems associated with morbidity data. As the Governments *Health of the Nation* put it: "Measuring ill health is ...much more difficult than measuring mortality. Whereas one death can be compared with another, morbidity covers a wide spectrum of physical and mental health, and from severe, but short term pain, to life long disability" (Dept. Of Health, 1992, p.29).

The availability of accurate and complete local morbidity data in Britain is limited. Self reported Long Term Limiting Illness (LTLI) data are provided by the census and registers are kept for certain disorders- notifications of infectious diseases and congenital malformations and cancer registrations. Data sources such as hospital admissions carry a health warning from health authorities. Elcha for example, does not consider them to be reliable (Elcha, 1994/1995). The London Research Centre point out that although high rates of hospital admissions may suggest higher levels of illness amongst the population, they could instead be indicative of differences in the local availability of hospital beds, or admitting policies (LRC, 1996).

Sociologists and others have argued that questions concerning the utility or otherwise of morbidity measures are compounded by subjectivity; a certain amount of self assessment is needed for an individual to consider herself or himself sick and for that individual to seek medical help. Doctors, in turn. will make a whole range of decisions related, not only to changes in medical knowledge, but to predominantly social factors as well (Parsons, 1951). Political considerations play their part: categories of ill health can vary in accordance with the requirements of the labour market and social security system (Whiteside, 1988). It is perhaps no accident that, in an effort to avoid considerations of subjectivity, much of the work on *health* inequalities, as we saw in chapter 3, concerns inequalities in *death,* yet even here, the objectivity of the official sources used by researchers cannot always be totally relied upon, (Atkinson, 1978; Hindess,1973; Slattery, 1986).

National self report surveys, including the General Household Survey and other large scale surveys such as Blaxter's Health and Lifestyles Survey, (Blaxter, 1990) are sometimes criticised on the grounds of lack of objectivity and uncertain reliability (see for example Carr & Hill, 1987). The same objections can be levelled at small scale local self report surveys. 'Disease' is sometimes distinguished from illness in survey research. Disease tends to be used in a limited and scientific sense, and illness refers to a person's subjective experience of ill health, (Jenkinson, 1994). A

problem, suggests MacIntyre, is that people's perceptions of their own health may be unrelated to their perceptions of the presence or absence of illness. GHS findings indicate high prevalence and incidence of reported illness co-existing with positive self evaluation of general health. (MacIntyre, 1986, p. 401). The literature has illustrated these kinds of anomalies. Although only 12% of respondents to a healthy lifestyle survey in Oxford claimed that their health was fair or poor, as many as 30% of the survey reported that they had chronic illnesses or longstanding disabilities (Wright, 1992). Jenkinson points out that the survey highlights the complexities involved in assessing health, and the myriad of meanings that people attach to the term 'health', (Jenkinson, 1994). Health involves something more than is captured in commonly used measures of morbidity (Albrecht, 1994). There is a general recognition that more work needs to be done on developing health indices as a measurement of the well being of the poorest (Field, 1996).

However, studies have reported that perceived health status predicts subsequent mortality, and is important in aspects of adjustment to major illness (Kaplan, 1983; Wannamethee and Sharper, 1991; Blaxter, 1990). A variation of questions used by Blaxter to assess self defined health status were used in my later interviews with residents, that is, " is your health better, worse or about average for someone of your age? " A copy of the interview schedule is included in the Appendix.

The health profile of the four boroughs considered as many quantitative health measures as were readily available in order to build up a general overview of the health status of the population. Health indicators were compared to the poverty and deprivation indicators for the four boroughs to assess the strength of the relationship between poverty and health at the local level and to consider whether London is in an anomalous position, and if so why.

Questions on health and illness included in semi structured interviews later included one on visits to the doctor and other health practitioners, as well as general ones on self evaluation of general health. The overriding aim in these interviews was not to collect precise health measure data however but to encourage interviewees to talk in general terms about their lives, and factors which affect their health and well being, their commonsense attitudes to health, and their social networks.

Policy responses to poverty, deprivation, and poor health

At the same time that data were collected on poverty, deprivation and health in the Lea Valley, local documents were sought on policy responses. Five policy areas were examined in relation to Tower Hamlets, Hackney, Newham and Waltham Forest: urban policy; anti poverty and community development ; housing initiatives; environmental initiatives, and health policies. The aim was

simply to identify and consider a few local examples, and not to provide a totally comprehensive coverage or make comparisons between boroughs. The purpose of this stage of the research was to investigate the extent to which policy responses were likely to impact on poverty and deprivation (both material and social) and health.

Broadly, responses examined can be grouped into those which focus on places, and aim to regenerate a deprived area, and those which focus on people, and aim for example to alleviate poverty (or improve the health) of vulnerable groups, or to involve people in the local community. Some policy developments contained elements of both. Sources included Government Office for London regeneration reports, The Policy Studies Institutes' *Urban Trends 1*, Housing Action Trust (HAT) reports, local authority housing plans, anti poverty reports, voluntary association reports, tenant group newsletters and reports, Health authority and FHSA documents. These were discussed in the light of literature on urban development, community development, the Priority Estates Project, *Health of the Nation* and conclusions on poverty and the economy reached in ' London's Other River'(Cattell, 1997).

Priority Estates Project work to encourage tenant management and participation on housing estates. To gauge the effect of PEP involvement locally I sent a copy of a questionnaire to PEP workers with experience of East London estates. The exercise was also part of the methods used to select an area for a case study, and to help firm up topics for the interview schedule to be used with residents. Three of the four questionnaires returned related to a number of estates in East London. They were in Hackney, Newham, and Tower Hamlets. I was unable to secure a reply for estates in Waltham Forest.

Because these various policy responses are somewhat peripheral to this research, an account is not included in the text but presented in the Appendix. Health responses are more central to this research and are included in chapter 6.

ii. The micro studies

Selection of population to be studied

Given the established relationship between deprivation of area and poor health, the area selected for a micro study would need to display high levels of poverty and deprivation as indicated by the Census. Such areas were not at all difficult to find in the Lea Valley. Evidence from PEP and the JRF on increasing concentration of poverty on housing estates suggested estates as locations rather than other forms of housing in poor areas. I was not attempting to prove that poverty and

deprivation affect health however- the evidence in the literature is solid, and the poverty and health data in the Lea Valley structural review confirmed these associations. An aim was to explore complexity and variability in the relationship between poverty, networks and health on the ground, and the difference that place can make over and above the socio-economic characteristics of residents. Factors associated with the local community, including opportunities for participation, were a particular focus. I planned therefore to select areas with similar poverty profiles rather than a deprived area and a better off area. To test working hypotheses on social networks, community, and health, that is, that positive healthy communities would be characterised by high levels of participation in organisations and initiatives, by flexible social networks, and attitudes of solidarity, some additional criteria were looked for. These were connected with the degree and nature of community participation. I hoped to find localities displaying some of the following characteristics: one vibrant sub area with suspected high levels of participation in local initiatives, one stable, traditional, neighbourly community, and one demoralised community with very little social interaction. Time constraints later restricted these to two, the first two. It later became apparent however that there were elements of the third model, the demoralised community in both of these, and, surprisingly, especially in the first.

Two methods were adopted to select suitable 'communities' on which to focus my research. The objective in both was to gauge a sense of the nature of community life and extent of participation. Firstly, practitioners in the four boroughs were asked to comment on the reputation of their areas or parts of their areas. Secondly, questionnaires- already described in connection with policy responses- were sent to PEP officials with experience of working on estates in East London. A resume of these can be found in the Appendix. In both cases, experts comments helped me to identify additional issues and features of areas which were likely to be important in the process of selecting an area and in conducting the research. For example, it was suggested that the reputation of an area could differ markedly between different parts of the same estate.

As part of the exercise to collect data on demographic features, deprivation, and health, across the Lea Valley region, individuals working in the boroughs of Tower Hamlets, Newham, Hackney, and Waltham Forest were contacted between late November 1995, and early January 1996, and in May about their knowledge of the reputation of their areas. Many were informally interviewed, most by telephone, but some face to face. Individuals were initially selected on a 'likely to know' basis and included academic researchers, Local Authority information officers, Policy and Planning people, housing officers and researchers, Health Authority officials and researchers in Public Health and FHSAs, as well as representatives from voluntary organisations, City Challenge, Economic

Development Units, co-operative groups and others working with tenants. A wide range of contacts resulted from this process.

Contacts were asked to comment on the reputation and levels and nature of community participation in the areas with which they were familiar. Voluntary groups, initiatives and other resources were said to be unequally distributed. Cathall, in Leytonstone for example, was reported to be well provided with groups and initiatives, and was said to have have a better community feel than others. Cathall is one of the estates selected for my case study.

To gauge a sense of the nature of community life and extent of participation in micro areas I approached Priority Estates Projects for help. A questionnaire was sent to PEP workers with experience of East London estates. The questions were designed to seek out their impressionistic views of the estates, and covered topics on sense of community, reputation, informal and formal participation, PEP involvement, and health. PEP returns were useful in highlighting additional relevant issues which might crop up in research and for identifying indicators corresponding to different kinds of 'communities' on estates. I decided not to research PEP estates because they have already been well researched (by PEP). The PEP material was a useful information source. It was not possible to judge from these questionnaires however, the extent of involvement in tenant organisations and other initiatives, or the kinds of people involved. Such questions, as well as information about informal social networks, bottom up groups (for example self help, co-ops and so on), health or any changes on health and well being of residents would be explored in interviews with residents, and through other ethnographic techniques. As a housing officer in Hackney commented " The only way to find out about estates is through depth research on the ground. You need to be plugged into the networks. "

As a result of these processes, two case study areas were selected: Keir Hardie estate (Newham) and Cathall estate (Waltham Forest) They were selected because:

a) they both are located in poor and deprived disricts. Newham is the most deprived borough in England on the Index of Local conditions. Cathall estate is located in Cathall ward in Leytonstone, one of Waltham Forests two most deprived wards on the Index of local Conditions, and more deprived than any of Newham's wards.

b) They differ according to the degree of intervention, such as central and local government initiatives and voluntary organisation involvement. Workers from umbrella organisations for the Voluntary sector indicated that Keir Hardie had been relatively neglected, and felt excluded from

nearby regeneration initiatives, including the Docklands Development, while Cathall was undergoing regeneration as a HAT estate and had a history of sustained community development work and voluntary sector activity. Community development workers on each estate confirmed these descriptions.

Both estates it later transpired, have poor reputations (especially Cathall), but I was not aware of this at the outset.

Qualitative research on Keir Hardie estate and Cathall estate

The value of in-depth qualitative research is that it can identify complexity and variability. It was clear from the literature review that the patterning of health inequalities is highly complex. Some researchers have argued for a multi-faceted yet meaningful approach to health determinants: "Research needs to be complex enough to understand a complex interplay of forces, yet significantly focused to get valid and meaningful results", (Jones and Moon, 1993, p.520).

Although qualitative research methods are generally seen as less rigorous in terms of representativeness and reliability than survey methods or the use of secondary sources (Bulmer, 1984, p. 210) their use is justified (in sociology) in that procedures reflect the nature of theoretical concerns in sociology, such as a concern with social relationships and social interaction. The selection of the research methods adopted at this stage of the research was influenced by the advantages of the method but also by a desire to give people a voice. Diverse writers have decried the imperfections of the democratic system, a system in which the poor are denied voice and influence. Holman put it succinctly: "The silencing of the poor is a mechanism by which poverty is upheld" (Holman 1994, p.13). A key feature of qualitative research lies in its commitment to view events, situations, attitudes and values from the perspective of those being studied (Bulmer, 1984). For the researcher, it involves a willingness to empathise with those being studied.

Michael Young's approach to interviewing can be mentioned here: this involves an implicit but profound respect for the individual respondent whose beliefs, attitudes and sentiments are being explored (Runciman, 1995). However, adopting a Chicagoan interactionist perspective, it is also recognised, that the focus needs to be, in addition, on the network of statuses and relationships in which the individuals experiences, attitudes and perceptions are embedded, (Plummer, 1983).

An additional advantage of qualitative research methods is that they facilitate a focus on process. Commenting on the fact that much is known about social determinants of health but little about the

processes intervening between social position and observed health or ill health, MacIntyre suggests that we need more prospective sociological research on unselected populations to explore the processes linking social position and health. She advocates a multi faceted approach which can consider and examine simultaneously some or all of the social positions associated with health- such as class, gender, marital status, age, ethnicity and area of residence. With studies using relatively restricted populations, consisting for example of one gender, one ethnic group, there is often a failure to compare findings systematically with other groups, (MacIntyre, 1986, p. 401). There is also the possibility of fallaciously over-generalising from the group studied, or making the equally fallacious assumption that the process or findings in question are unique to the groups studied, (MacIntyre, 1986).

The benefits of a multi faceted approach are evident when researching complexity and variability as well as researching process. All are features of this research. MacIntyre suggests that because forms of disadvantage related to ill health are themselves inter-correlated - ethnic minority, unskilled worker, unemployment, living in an inner city, being a single parent- that disaggregating these components may mask the effects of overlapping vulnerabilities (MacIntyre, 1986, p. 400). Given that a primary focus of this research is on variables which intervene between social position and health status and well being, particularly social networks, and on the mechanisms involved in health causation or protection, then the kind of multi faceted approach advocated by MacIntyre seemed appropriate. This research is not restricted to any one population group, or form of disadvantage, the only restriction concerns living in the selected, poor and deprived area (as indicated by the Census). It is arguably a high risk strategy, given the usual admonitions given to PhD researchers to say a lot about a little rather than a little about a lot (see for example Silverman, 1993), yet given my general commitment to a holistic approach, the broad brush strategy adopted at this stage was the only one I could feel comfortable with.

There are also valid theoretical justifications for this approach. The tendency in analyses of poverty to focus on the plight of people living in particular circumstances such as old age, sickness, large family size, single parenthood, and low pay, amounts, argues Westergaard, to a fragmentation of research in inequalities. There has been a reluctance, he argued, to recognise the common source of class division, (Westergaard and Resler, 1976, pp. 19-20). Townsend too has singled out social class as a major determinant of poverty, insisting that it must not be regarded as just another social indicator like employment status - but as a total reflection of differences in rank and economic and social position (Townsend et al,1988, p.10).

An additional feature of qualitative methods is that situations are not divorced from the wider social and historical context in which they take place. The emphasis on context, on interpretative understanding , on seeing social life as processional rather than static, stems from interactionist theory. Ideas espoused in the Chicago School literature stressed the individual's subjective interpretation of a situation as key as well as the subjective constraints which impinge on her or him, (Thomas and Znaniecki, 1918; Mathews, 1977; Plummer, 1983). An emphasis on context is not restricted to the Chicagoan philosophy. Cornwell's chosen research methods for her study of families and health in Tower Hamlets, appear to be relevant to a Marxian theoretical perspective. She argues that "... ethnographic material will bear witness to the part each person plays in shaping the course of his or her own life without losing sight of the fact that they do so in conditions that are not of their own choosing" (Cornwell, 1984 .p 204). She did not abstract health and illness for study but treats them as part of ordinary, everyday life. Ethnographic methods, were, for her, " the most appropriate way to investigate people's lives as a whole, whilst at the same time paying particular attention to their relationship to health and illness "(Cornwell, 1984 p.203). A similar approach was adopted in my research.

Symbolic interactionism was a development of the Chicagoan philosophy. There is a strong affinity between interactionist theory, argues Plummer, and methods which espouse the life history- a person's subjective definition of reality of the moment will not tell us about how those definitions differed in the past (Plummer 1983). Life history can be a useful means of exploring process. Becker, who examined becoming deviant as a process, argued that the life history more than any other technique except perhaps participant observation, can give meaning to the overworked notion of process (Becker, 1966; Plummer, 1983). Life histories can also be a means of exploring how aspects of social and economic structural change can impact on the life of the individual (Thompson, 1978). Another historian argues: "Society is a process. It is never static...the most challenging of tasks is that of re-capturing that process, while at the same time discerning long-term shifts in social organisation, in social relations and in the meanings and evaluations with which social relationships are infused" (Wrightson, 1982, p.12)

Not neglecting aspects of an individuals' life history has been shown to be particularly fruitful when researching health. When interviewing East End families about their experience of health and illness, Cornwell found that people frequently told stories about their own and other peoples experiences. Illness was seen as a product of a causal chain of action and reaction which takes place over time (Cornwell, 1984). Like Cornwell, I did not take a straightforward life history from

respondents, but adopted interviewing methods in which people's past experiences were integral, though for my purposes, secondary, to people's accounts of their current lives. Largely, this meant relying on accounts when offered by the interviewees themselves, but a limited number of targeted questions which encouraged people to talk about the past were also included..

Of course, there are methodological problems associated with oral history, some of which are shared with other qualitative methods, like depth interviewing, and which are related to its credibility. It has been argued, for example, that an individual's long term memory may be unreliable, and that the present determines recollections of the past (Lawrenson, 1997). Yet Thompson, an advocate of oral history techniques, maintains that recurrent processes may be better remembered than single incidents. (Thompson, 1978; Lawrenson, 1997).

The Fieldwork

The depth semi-structured interview was adopted as the major research tool in this research. Standardised, closed questions would not have been appropriate for my purposes. Within an interactionist perspective the primary purpose is to generate data which can give an authentic insight into people's experiences. Unstructured open ended interviews as well as in depth participant observation are the main ways to do this (Silverman, 1985). A semi structured interview schedule was adopted as it allows people to answer more on their own terms than the standardised structured interview permits, but allows for greater comparability than the completely unstructured interview (May, 1993). Given that I was researching two estates, a semi structured format was appropriate.

Documentary sources were accessed to gain information on activities in the area, but this work was limited by time constraints.

Observation focused on places where people gathered, including community centres, schools, churches, estate offices, shops, parks, cafes, play groups and voluntary organisations, as well as premises used by Koran groups, tenants associations, and self help groups. Each neighbourhood was observed at different points in time during the day, and on weekdays and weekends. Night time visits would have provided a more rounded picture, especially in relation to the activities of young people. I spent approximately four-five months in the field, two/two and a half months on each estate.

Interviews

There are a number of problems involved with the use of interviews. Interviewer bias is one of these. Reflexivity allows the researcher to reflect upon her/his role in the research process.

Hammersley and Atkinson argue that instead of treating the effects of the researcher on the researched merely as a source of bias, we should exploit it. How people respond to the researcher may be as informative as how they react to other situations (Hammersley and Atkinson, 1983).

Though interviews are generally a preferred method for obtaining greater validity, it cannot always be relied upon. However, the advantages of interviews are many: they offer a rich source of data (Silverman, 1985). Importantly, they are flexible, they allow for the generation of new ideas or issues which the researcher may not have previously thought of Bott for example, had been unaware of the importance of friendship networks to conjugal roles before she began interviewing (Bott, 1957). A method which allowed flexibility was essential for my research.

Three categories of informants were interviewed - residents, adjacents, and professionals. In each neighbourhood interviews were conducted with 30/40 residents and adjacents (a small number of people in adjoining streets) and with approximately 15 professionals, practitioners, policy makers, or people whose work takes them into the neighbourhood. On Keir Hardie the latter included a community development officer, voluntary sector workers, a housing officer, a caretaker, a Catholic priest, a Church of England vicar, a female Methodist vicar, an undertaker, a councillor, a nun involved in community development projects, a youthworker, a councillor, and a Newpin worker. On Cathall they included a community development officer, a childcare development officer, a childcare network officer, a community policeman, an educational visitor, a caretaker, a voluntary sector officer, an Area Improvements Initiative Officer, a childminding co-ordinator, a local vicar, a Waltham Forest Social Justice Committee officer, a Community Health Project worker (on a nearby estate) and workers for disability groups.

Thirty- seven residents were interviewed on Keir Hardie, 15 of these were in the 20-39 age group; 14 in the 40-69 range, and 8 over 70. The geographical isolation of Keir Hardie estate made access to outsiders difficult. There were 3 or 4 in this category. On both estates, the majority of those interviewed were women. On Cathall 32 residents and adjacents were interviewed 25 of whom were residents and 7 people living adjacent to the estate. The age range was similar to Keir Hardie, but there were fewer in the 40-69 years category. Middle aged residents were more difficult to track down on Cathall than on Keir Hardie.

Selecting people to interview

Major barriers to effective qualitative research concern problems of access and representativeness. Interviews were grounded in participatory observation and through contacts rather than selected

from a random sample. Though there are clearly benefits to the latter approach in terms of assumed lack of bias, it was nevertheless felt that many of those I wished to access, that is, those who are less active locally, less confident, less trusting of strangers, might well not respond. During the research, it became clear that several respondents would not have agreed to the interview had they not been approached by someone they knew who had already been interviewed or had met the interviewer. Such people were able to reassure them that the experience was not alarming, and might even be enjoyable. Informal sponsorship or the use of "gatekeepers"- has been used in classic qualitative studies (Liebow, 1967; Whyte, 1981; Gouldner, 1954). The method does not eliminate bias but its flexibility allows reflection and enables repeated efforts to be made to get the balance right. Moreover, getting it right is not always immediately obvious at the outset.

I decided not to adopt a structured approach to selection, by taking, for example, a sample of a block, or a street. Apart from inconsistency with the general ethnographic approach adopted, there can be problems connected with confidentiality with this method. Abrams for example found people were reluctant to talk when they knew that their near neighbours were to be interviewed also (Bulmer, 1986).

Instead, representatives of external agencies, as well as professionals interviewed in the early stages of fieldwork, were asked to approach possible interviewees on my behalf where appropriate, and to identify key informants. In some cases, this was successful, in others not. I planned to explore contact agencies in the way that Bott had done for her study, and like her, found results variable. As well as those contacts already mentioned and whom I interviewed, I also telephoned, visited and wrote to missions, GPs, child and baby clinics, health visitors, community nurses, and various people working in social services. Although people I spoke to in social services were generally willing to help, and indeed passed on details of the research to their colleagues, only one contact emerged as a result. A problem concerned authority and staffing structures. For example, a person at a certain level, say a home help manager, was needed to give permission for staff on the ground to be involved. The manager may have been sympathetic to the research, but were not in a position themselves to contact clients on my behalf. Staff working closely with clients may not have seen the need, or had the time, to help. I drew a complete blank with the health services in both boroughs. Again, though certain individuals were willing, there were problems connected with authority and, in some cases with ethics. Research involving patients needs to be cleared with ethics committees, in some cases, a process which can take months. Any future research would need to make such clearance an early priority. I received no replies to letters sent to General Practitioners. Bott had come up against similar problems with GPs in her study of families and social networks, and

suggested that doctors were unwilling to jeopardise their relationship with patients by involving a researcher. I was surprised however by the lack of response shown by GPS, this had not been a problem for me in previous research when interviewing patients using primary care services for the College of Health. Despite these hiccups, people in agencies other than Social Services and the Health Authorities, were generally very helpful The whole process was much easier on Keir Hardie than it was on Cathall, a reflection, no doubt, of features connected with the different social organisation of each area. An additional problem on Cathall concerned the bewildering numbering system of the flats. Even residents found it difficult to find their way around, let alone geographically challenged researchers.

Selecting people to interview was through a process of what I refer to as "selective snowballing". As well as following up contacts suggested by professionals, people directly contacted through participant observation were asked to participate in the research. (Visiting clubs and voluntary organisations, toy libraries and after school clubs, asking directions in the street, talking to people in shops and cafes, were some of the approaches used). Interviewees were asked if they knew a neighbour who would be willing to talk. The aim was to produce a broad coverage of active and non active residents. With the notion of Weberian 'Ideal types' in mind (Gerth and Mills, 1948) efforts were made to include the "ordinary" resident, the less active, less confident, as well as the outgoing and participatory individual. A balance was thought necessary given the emphasis on exploring the benefits of participation built into the research design. Those whose degree of participation has recently changed were found to be among the most interesting of the informants.

In addition, it was hoped that those selected would reflect the socio- economic and demographic make up of the neighbourhood; categories included age, ethnicity, and household composition. Almost all were unemployed, retired, or with childcare responsibilities. The few in work were on low wages. Teenagers and young people without children were excluded, partly to restrict the size of the sample, and partly because it was assumed that the locality, and local facilities were of less consequence for these groups than for others. This turned out to have been an erroneous assumption. On both estates residents complained about the lack of facilities for young people. Any future research on these estates would need to incorporate the views of young people. Indeed, conflict between the older and younger generations was to some extent evident on both estates.

Representativeness is a key concern when qualitative methods are being used. Although Plummer suggests that a key informant who is willing and able to talk about a subject is more important than a representative sample (Plummer, 1983), Lawrenson argues that 'the validity of the data arrived

at from informants must be shown to be generalisable, and that the representativeness of the evidence is something that can be achieved theoretically by the social scientists' (Lawrenson, 1997 p.17). "A social scientific understanding of any social process involves the triangulation of evidence and the attempt to build a coherent story by linking it to evidence about related processes and sociological generalisations" (Lawrenson, 1997, p. 21). Multiple accounts of social processes need to be made coherent.

It has been argued that the process of achieving access is not merely a practical matter. The discovery of obstacles to access, and effective means of overcoming them, itself provides insights into the social organisation of the setting. Negotiating access, data collection and analysis are not distinct phases of the research process, (Hammersley and Atkinson, 1995). It became apparent during the research that who I gained access to without much difficulty, or where access was problematic, said much about the social organisation of the estates and the services available. On Cathall for example, access to parents with young children was relatively easy, a reflection of the facilities available, and of sustained outreach work by local agencies. On Keir Hardie, elderly people - though not the most isolated elderly- were easily accessible: their long term links with the area, as residents and local workers, led them to take a prominent role in local social and associational life. Access to men emerged as a problem on both estates, a reflection perhaps of lack of involvement in community life and patterns of neighbourliness, but also perhaps a function of inadequate attention paid to trying to gain access to men on my part and to alter my research methods accordingly.

The Interview Schedule

Interviews with residents included questions which explored their perceptions and changing perceptions of their neighbourhood, and factors which influence these perceptions. Questions designed to discover coping strategies as well as needs, resources and networks included variants on the "describe a typical day " advocated by Plummer amongst others, (Plummer, 1983) and used with effect in earlier research for the College of Health. Others explored the characteristics and structure of social networks, the support given and received, participation in formal and informal organisations, their attitudes to the wider society, and their hopes and aspirations for themselves, their families, and their neighbourhoods. Questions on health referred to their current self assessed health status, and in addition respondents were asked to reflect on their life and health history, and to comment on the factors which they believed were important in influencing health.

Interviews with people in adjacent geographical neighbourhoods focused especially on their

perceptions of that area and any contact with its residents. The purpose of these interviews was to glean information on public perceptions of stigma relating to the estates, and social exclusion of estate residents. They also provided a means of comparing perceptions of community and social networks of estate and non estate residents, a means of testing the extent to which very localised conditions made a difference to peoples lives. Interviews with representatives of external agencies focused on their perceptions and experiences of that neighbourhood.

A copy of the interview schedule used with residents is included in the appendix. It was piloted amongst colleagues and friends. I discussed the schedule with two leading academics- Peter Willmott and Janet Foster. Peter Willmott made helpful suggestions on the wording and order of questions which were incorporated into the schedule. With Janet Foster I discussed the difficulty of getting information about respondents social networks whilst adhering to a flexible semi structured interview approach. She agreed that precise questions on network structure (a method generally adopted by social network researchers) were inappropriate within this framework, that they would interfere with the hoped for flow of conversation. She suggested that I conducted follow up interviews with selected respondents in which I would put precise questions on social networks. This I fully planned to do, but time restraints prevented me from doing so, and in any case, I felt that the interview data was sufficiently rich for this stage not to be absolutely necessary. Talking to Willmott and Foster gave a boost to my confidence, and confirmed the rightness of opting for qualitative research methods, rather than a social survey.

An understanding of people's social networks is an essential feature of this research. An individual's social networks can be seen to be considered from three angles. Firstly, from the point of view of the characteristics of the people in that network, such as the type of relationship - family, friends and neighbours, and can also concern such features as age, employment status, ethnicity and class. The second approach focuses on the structure of the network- its extensiveness, patterns of proximity, frequency of contact, and density. Third, there are the functions that networks provide. The functions, benefits of social networks, especially in relation to health, are described in chapter 4.

Abrams saw the potential for network analysis for understanding change in patterns of neighbouring and the dynamics of community life. Arguments about the decline of community are largely arguments about the decline in *density* of social networks (Bulmer, 1987; Frankenburg, 1966) but Abrams recognised that research techniques involving network analysis , by giving equal weight to all links in the network, neglects the significant content of relationships (Bulmer, 1986). Both

structure and content were important for me to consider when looking at the complexities involved in the relationship between social networks and health. Network analysts typically adopt one of two approaches. The first involves taking a defined spatial area and mapping all of the linkages inside it. The second conceptualises an ego centred social field and involves tracking all of the contacts of one person, (Wallman, 1984). Neither seemed appropriate given the generally ethnographic field methods adopted, and the relevance to health of meanings of networks, and their value.

To reveal the meanings of links in an individual's social networks, as well as propinquity, Wallman compiled two maps for each household's network in the households she studied. One recorded geographic distance of people in the network, the other classified contacts in terms of emotional or resource value. Both maps contained space for difficult or hostile relationships. I considered using or amending these maps to incorporate density, but realised that the recording of such precise information might well interfere with or prevent the natural flow of information which I was seeking. I was in any case, less concerned with total accuracy in terms of numbers of contacts and geographic location, and more with the general patterns (including structure) of residents networks, the extent to which the locality was an influence, the benefits which people derived from their networks and any attitudes and attributes which might be associated with their networks. Precise measures, do, in any case, involve time scale problems. As Wallman herself points out, relationships, to anthropologists, '...are not units, they are processes whose meaning and value changes in response to other things going on at the time' (Wallman, 1984, p. 68). I hoped in any case, that some of the kind of information which the maps were designed to elicit, as well as the additional areas which I was focusing on, would emerge through discussion based on the semi structured interview format. I was in addition, dealing with a far larger number of cases than the eight households in Wallman's study.

The topics on the interview schedule (see Appendix) were intended as an aide memoir. As well as open ended questions, basic factual information on age, household composition, work, ethnicity, was also collected. The order, or range of topics in the interview schedule was not rigidly adhered to, although I tried to cover all the broad topics in general terms. Some explanation on the choice of questions is provided below.

1)living in this neighbourhood

These questions were designed to explore residents' positive and negative perceptions and changing perceptions of their community/neighbourhood, and the factors which influence these, as well as stability or instability of population; neighbourliness, local facilities; and informal resources.

2)social networks/ people you mix with, have contact with

These questions were designed to explore the characteristics, structure and functions of networks; attitudes to mixing and co-operation with like and unlike groups. Sub questions g and h are intended to explore the quality of networks, and the extent to which they are a positive or negative resource.

3)activity

These questions were designed to explore the opportunities available for involvement; the extent to which various agencies are successful in encouraging involvement and blocks to involvement; the benefits which people derive from participation in formal and informal organisations and the extent to which they are a a coping resource; network structure; links with wider networks; and how any of these may impact on health.

4)support.

These questions were designed to explore the extent to which people in disadvantaged areas help each other to cope, the extent to which people ask professionals and so on for help, the conditions under which these occur, which people are important in giving support, whether reciprocity occurs; and the mechanisms by which support may be beneficial to an individual's health.

5) attitudes, ideas and values

The overall aim of these questions was to further explore mechanisms by which attitudes may affect health indirectly or directly. The questions were designed to explore residents' attitudes to the wider society and political system; the degree of apathy, hope, optimism, and realistic responses to circumstances. The questions were also designed to enable examination of whether attitudes are related to characteristics of networks.

6) making ends meet

This question aimed to explore the extent to which people cope financially or not, to explore the effects of poverty in respondents' lives, and to explore the mechanisms involved in the relationship between poverty and ill health.

7)health

These questions were designed to encourage people to talk generally about their health, their commonsense ideas on and attitudes to health and well being, as well as to gain some impression of their current and recent health status.

8) life history and health

The questions were designed to encourage residents to talk freely about their life experiences and health experiences. I wanted to gain some insight into communities at different times and in different places, and what makes for satisfaction, as well as the role of work, and significance of

life stage. As Townsend points out, one of the problems involved in disentangling the effects of deprivation is establishing the length of exposure of individuals to its effects (Townsend, 1990, p. 10). It would have been foolish to make assumptions about a person's current health status and their network patterns, attitudes or poverty without some idea of their past health and life history. The question's overall purpose was to gain a better understanding of the processes and mechanisms involved in health experiences. Question 8c, on whether people thought that circumstances affect health, was designed to uncover residents own attitudes to health determinants. It worked quite well, but the last question, on whether respondents thought that social networks affected health, did not work well in every case. I tried re-wording the question to ' what about people', but the answers were variable.

Ethics

The Social Research Association's ethical guidelines suggest that researchers have certain obligations, and that these include an obligation to those who participate in the research, the 'subjects' (Dean, 1996).

When working with poor people, in poor areas, researchers are faced with specific ethical problems. People taking part in Corden's research objected to the use of the term 'poverty', for example, they felt that it had very negative connotations, and that they, and their area, were stigmatised by it. Subsequent research she conducted in the same area did not specifically address poverty, but sought to explore people's feelings about living in the local area, and about their experiences of living on a low income, (Corden, 1996). A similar approach to introducing the subject of poverty with respondents was taken in my research.

Developing trust, establishing rapport, are generally seen as essential preconditions for the successful interview (Finch, 1984). There may be an element of exploitation involved however, when interviewing those less powerful than oneself, or indeed simply lonely. (Finch, 1984). My response to this problem was built into the methodology, and involved the encouragement of interviewees to tell stories. Cornwell distinguished between the public accounts which her interviewees gave in response to their experiences of health and illness, and the private accounts. The former involve answers to direct questions posed by the interviewer, the second happened when people were invited to tell a story. Cornwell suggests that a subtle shift in power occurs when the two approaches are adopted. When the interviewer is asking questions, the relationship between the interviewer and interviewee is controlled by the interviewer, when people are telling stories, the story teller will be more in control, (Cornwell, 1984, p. 16).

In an influential article, Oakley took to task conventional text book approaches to interviewing in which the interviewer receives but does not give information. She advocates less structured, informal research strategies in which interviewer and interviewee interact "...the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship" (Oakley, 1981, p.44). Because Oakley felt that she was asking a great deal from the women she interviewed in the way of time, co-operation and hospitality, it was right that she should give something in return, such as information about herself, and advice when it was asked for. Oakley was influenced by Zweig, whom she quotes: "I never posed as somebody superior to them, or as a judge of their actions but as one of them" (Zweig, 1949, p.2).

I adopted the Oakley approach in my interviews with people on the two case study estates. I was conscious of the need to establish relationships of equality, and reduce as far as I could the exploitation element involved in interviewing people in deprived circumstances. These were interlinked. Just as relationships of inequality and exploitation go hand in hand, then, one would expect, by attempting to establish relationships of equality, one would reduce the tendency to exploitation built in relationships of inequality. Similarly, to minimise exploitation would reduce the element of inequality in the interviewer/ interviewee relationship. Influenced by Abrams' work on the conditions under which people are neighbourly and helpful, I saw reciprocity as the key, (Bulmer, 1986). If I was taking, I had to give something back.

I did this in three ways. Firstly, by offering information about myself, my family, ideas, and health when it seemed appropriate, though not of course, to the extent that this dominated the conversation, or set the agenda. The research situation, did, I hoped, have more in common with a normal conversation than with the formal interview, even if, it was a conversation in which one person did most of the talking.

Giving something of yourself helps to establish relationships of equality, especially in so far as the information offered suggests that interviewer and interviewee have something in common. For Oakley, 'sisterhood' provided a vehicle for overcoming inequalities between the interviewer and the interviewee. Common experiences I could share with some of the women I interviewed included having children, and being a single parent. Sisterhood however, as Cornwell noted, may not be enough to overcome differences of class (or indeed gender). There is no disguising the fact that I, as a researcher, am doing a middle class job. Yet I was not aware of a perceived sense of distance

between myself and those I interviewed, on their part or mine. We had many things in common, and these would come out in the interview, as they might in any normal social interaction. Having local and family connections helped. In the case of the Leytonestone estate, having some familiarity with the wider area as a result of living in the same borough, and in the case of Keir Hardie, a father who had been a dockworker.

The second approach adopted here involved giving some of my time to the respondents. Like Cornwell who researched family lives and attitudes to health and illness in East London, to some extent I allowed those I interviewed to direct the course of the interview. People did not always want to talk about what I wanted to talk about. Sometimes, especially in the case of some of the elderly respondents, or those who had recently experienced difficulties in their lives or relationships, there were certain issues that they wanted to get off their chests. A neutral listener was welcome. Occasionally I virtually abandoned the interview schedule, thereby putting more power in the interviewees' court. The result was sometimes material I was not able to use, or did not want to. Sometimes however I stumbled on something which I had not thought about asking, and which turned out to be highly relevant. An example concerned the links between the pensioners clubs on Keir Hardie, and peoples' experiences of social clubs in the factories and docks where they worked in their youth. Another was a reported tendency for some estate residents on Cathall to set fire to their flats in the hope of getting rehoused.

The third strategy adopted was to give small gift vouchers by way of thanks. These may have been simply a sop to my conscience, but the small amounts involved were welcome to people living on very low incomes. Before embarking on fieldwork, I canvassed the opinions of researchers on the ethics of payment, including a researcher at the York Social Policy Research Unit. It was suggested that money might cause difficulties for people on benefits, while gifts could be inappropriate and difficult to manage. Gift vouchers seemed a reasonable option.

In the end however, I must admit to only partial success of these strategies. I inevitably gained more from the people I interviewed than they did from me. I was not in a position, moreover, to sustain these newly formed relationships, or let embryonic friendship develop. I felt uncomfortable about this, as well as sorry. In most cases, I did not take up offers to drop in for a cup of tea another time, my work schedule did not allow it. Nor did I take up an offer to accompany one woman to a church meeting: I was not sufficiently religious to want to attend for the 'right' reasons, and was anxious not to exploit her good will and kindness for the 'wrong' reasons, that is for the purposes of research, as an observer.

Analysis of interview data

There can be ethical problems involved in writing up interviews. Corden was concerned to protect participants' interests and maintain their confidentiality. She decided not to write up the interview data verbatim on the grounds that "...presenting blocks of regional phraseology, with the interrupted sentence construction that characterises spoken language, alongside my own standard English grammatically organised written prose, might actually stereotype and stigmatise the speakers" (Corden, 1995, p. 17). My own approach was to adopt a compromise position. Extracts from interviews have been presented largely as they were spoken, but without the ums, ahs, and convoluted sentence structure which many of us use in speech.

Although previous stages of the research had formulated ideas to be explored via the interviews with residents, and influenced the questions put, I did not want these ideas to dominate analysis. After all, the hypotheses on which they were founded could have been wrong, or if not wrong, simply a sideline to a wider picture. The semi structured interview format, and open, interpretive and interactive approach, meant that additional topics, could, and did emerge in discussion with residents. These topics would influence the generation of any new theory. The grounded theory approach places emphasis on induction and openness, categories are expected to emerge in the course of the analysis(Bulmer, 1984; Glaser and Strauss, 1965).

The analysis of the interview data is based on the people studied. It is, to a large extent grounded, that is, analysis is inductively derived. Grounded theory is " a general methodology for developing theory that is grounded in data systematically gathered and analysed" (Strauss and Corbin 1994, p.273). I tried to adopt the methodology of Glaser and Strauss, who urge researchers to avoid forcing round data into square categories; categories should emerge in the course of analysis (Bulmer, 1984, p.255).

Data for each estate were considered in turn, beginning with Keir Hardie. I describe below the mechanical and thought processes I went through. Glaser and Strauss stress the importance of the detailed elements of the actual strategies used for collecting, coding, analysing, and presenting data when generating theory, (Glaser and Strauss, 1967, p. 224).

Interviews were typed up as individual cases. They were read through, and emerging broad themes noted. The interviews contained data on both community level variables (ecologic) and individual level, and provided information which could be used to explore the relationship between place and

health and individual characteristics and health. It seemed appropriate to separate the two at this stage with a view to making links at a later stage of the analysis. A dichotomous division was therefore adopted. I aimed for mutually exclusive broad categories but a small amount of overlap was inevitable. Data were identified for each case which related to: a) residents' and professionals' perceptions towards and experience of living or working in the neighbourhood, and b) residents' individual social networks, life history, attitudes and health.

The neighbourhood data.

I read through the neighbourhood data once more and wrote a very brief summary of the interviews as a whole in note form arranged under headings. Headings were derived from themes emerging. In some cases, topics had not been directly sought through the interview schedule , but nevertheless emerged as key features. Examples included comparisons made by Keir Hardie residents with life on the estate in the past. Strauss and Corbin describe different modes of interpretation: "Qualitative modes of interpretation run the gamut from 'Let the informant speak and don't get in the way,' on through theme analysis, and the elucidation of patterns (biographical, societal, and so on), theoretical frameworks or models..., and theory formulated at various levels of abstraction." (Strauss and Corbin, 1994, p.278). I adopted theme analysis for the neighbourhood data, and used models for the personal data (see below).

I went back to the interview data, highlighted key words and phrases, indexed the data under headings and sub headings already identified. To do this, points were given a code number, and these numbers inserted against the list of headings and sub headings (codes). I aggregated the data under the headings on the computer and included everything to provide a continuous descriptive account. Personal details were retained so as not to lose context. An over riding aim of this and later analysis was to retain individuals in their time and place. As Strauss and Corbin insist, the work involved in grounded theory is interpretive, and " interpretations *must* include the perspectives and voices of the people whom we study", (Strauss and Corbin, 1994,p. 274).

Some interpretation was introduced at this stage, categories refined and some material moved.. Hammersley and Atkinson describe Glaser and Strauss's constant comparative method- the analyst examines each item of data coded in terms of a particular category, and notes its similarities and differences to other coded data. In this way, new categories or sub categories emerge and there may be a considerable amount of reassignment of data among the categories (Hammersely and Atkinson, 1995, p 213). As the systematic sifting and comparative process develops, the mutual relationships

and internal structures of categories will be more clearly displayed (Hammersley and Atkinson, 1995, p 213).

Theories concerning the influence of various neighbourhood factors on social networks began to emerge.

Networks/attitudes/health/ personal history data

I then turned to the until now unanalysed personal data, read through it, and noted overall themes. I read through data again case by case, and added a few lines to each case which identified key aspects of interviewees lives, their social networks, and their health. Points noted included information on household composition, patterns and characteristics of their social networks, whether involved in community life, and their self assessed health. These notes and keywords constituted preliminary codes to be used for further analysis.

At this stage I considered either writing an aggregated account under themes emerging, with some further analysis under alternative ways of looking at the data, or b) retaining each as a case study. I rejected the first approach as I was concerned that the interrelationships, influences, links in the chain, I was seeking from the data could be lost. Grounded theory researchers are interested in patterns of action and interaction between actors. They are concerned with discovering process, and with changes in patterns of action/interaction and changes in conditions (Strauss and Corbin, 1994, p 278). The second approach, that is presenting individual case studies, was a more attractive option in that individuals would be retained in their time and place, but in this case, it might be cumbersome, important themes could be submerged and any generation of theory difficult. Looking again at the summary notes/codes I had made on each case, It became clear that residents social networks consisted of groups of different categories of people, and that there seemed to be an emergent pattern relating to groups and other key themes, such as attitudes and health as well as other characteristics of the network. In order to focus on groups when analysing networks and their functions rather than simply their size, Bott's concept of membership groups was adopted as a means of categorising groups. Bott uses the concept of membership groups to describe the groups an individual belongs to- for example neighbourhood, family, work, unemployment, neighbours, clubs etc. She compares these to reference groups which the individual may or may not belong to and which affect their behaviour, (Bott 1957).

I wanted to move towards a typology which retained individuals in their time and place and yet

allowed comparison with other cases. Models were then constructed based on the range of membership groups in an individual's network. Models are an abstract way of presenting the relations between social phenomena. They provide ways of simplifying and understanding essential social mechanisms, (Abercrombie et al, 1984, p.158). MacIntyre suggests that it may be fruitful to develop multi dimensional models , including models of 'social' health (MacIntyre, 1986).

Individual interview data was assigned a network type. Most respondents slotted quite easily into models, others did not present a totally accurate fit; where this occurs, I note the variation. Grounded theories are very fluid. As Strauss and Corbin argue: "[Grounded theories] have a striking fluidity. They call for exploration of each new situation to see *if* they fit, how they might fit, and how they might not fit. They demand an openness of the researcher" (Strauss and Corbin, 1994, p. 279). The data was read through once more, key words highlighted, and themes emerging noted. The data for each network model was indexed according to headings and sub headings. Interviews relating to each network/membership group category were aggregated under headings. When interpreting the data, I tried to maintain a balance between cross cutting themes , context and illustration of processes.

The models were examined to see if they bore a relationship to health or attitudes and attributes associated with health. It became apparent that the functions that networks provided, and health protecting or damaging attributes varied to some extent with network models. To develop analysis further, the concept of 'reference group' was introduced as a way of aiding understanding issues connected with the way that people choose to mix or identify with others. Grounded theory methodology, according to Strauss and Corbin, is designed to guide researchers in producing data that is conceptually dense- with many conceptual relationships. The relationships are embedded in a thick context of descriptive and conceptual writing (Glaser and Strauss, 1967, pp.31-32). Theory began to be generated from the typologies.

So that assumptions were not made prematurely, and to give all respondents a voice, no data were excluded until the final stages of the analysis, when only repetitive data were omitted or data which were totally extraneous to the analysis.

The second study area

The whole approach was repeated for the second case study area, Cathall. In terms of the neighbourhood data, there were some similarities in the themes emerging to those on Keir Hardie,

but overall, there were more differences. Crime and fear of crime for example stood out as a major influence on opportunities for forming thriving social networks on Cathall. When I turned to the data on individual networks, attitudes and health, in order to 'test' the explanatory value of the models, I tried initially to impose them on the Cathall data. I soon abandoned this approach, firstly, because it did not work, and secondly, and more importantly, grounded theory is a methodology which encourages the development of theory through the interplay with the data itself. In the development of a typology there must be constant recourse to the material one is analysing. Moreover, as Bulmer reminds us, grounded theory is not seen as producing total explanations, nor is it concerned with proof (Bulmer, 1984, p. 255).

When writing up the conclusions, relationships were identified between community influences on patterns of social networks, and individuals' social networks and the implications for health, Interpretation also focused on differences between estates.

SUMMARY

1.This research utilises both quantitative and qualitative methods to explore the dynamics between poverty and community, people and places, and how they can interact to affect health.

2.Health is treated holistically, and includes 'well being' formulations. Ill health is not restricted to any one disease or indicator.

3. The research explores structure, meanings and processes via a local case study. There were 2 stages:

i) a statistical overview of demographics, poverty, deprivation and health in the wider geographical area, and

ii) a qualitative study of 2 micro areas.

A comparative approach based on localities was expected to provide a better understanding of the role of place, and intensive on the ground qualitative research would enable a better understanding of the interrelationship between poverty, community, social networks and health.

4. The Lea Valley region in East/North East London was selected for the structural overview as it contains some of the most deprived boroughs in England, and because London has been seen as something of an anomaly in health terms. The deprivation topics selected for inclusion were all those implicated in the literature on social inequalities in health, and which were confirmed by Morris and Carstairs as highly correlated with poor health measures. Sources included the Census of Population, Census based surveys and local authority and heath authority data. Secondary

analysis was a useful means of comparing areas and of studying trends over time. The structural overview was published as 'London's Other River'.

5. Local data were analysed to address some of the questions on the importance of spatial considerations in measuring poverty and the relationship between deprivation and ill health. The deprivation scores on three separate ILC measures were examined for Lea Valley boroughs; local boroughs position on different deprivation indices were analysed and discussed; Green's measure of isolation was considered for the Lea Valley as a proxy for 'concentration'.

6. Available health data were examined to build up a general overview of the health status of the population of four Lea Valley boroughs. The health and deprivation profiles of these boroughs were compared to assess the strength of the relationship between poverty and poor health at the local level, and to consider whether London is in an anomalous position.

7. Local documents were sought on policy responses with the aim of investigating their likely impact on material and social deprivation and health.

8. Micro areas for the qualitative study were selected on the grounds of similar deprivation, and dissimilar opportunities for participation. The second was considered necessary to test working hypotheses on social networks, community and health. To aid selection, practitioners in the four boroughs under consideration were asked to comment on the reputation of their areas, and questionnaires were sent to Priority Estates Officials with experience of working on estates in East London. Two case study areas were selected: Keir Hardie estate in Newham, and Cathall in Waltham Forest. The former had been neglected in terms of initiatives and voluntary groups, the second was well provided.

9. Qualitative research can identify complexity and variability, and facilitates a focus on process - all features of this research A primary focus of the qualitative research is on social networks as mediators between social position and health, and place and health. A multi faceted approach , in context, seemed appropriate. The research methods adopted are primarily informed by interactionist theory, but Marxist theory which recognises present and past constraints on peoples lives is not neglected. The influence of feminist approaches to research methods resulted in efforts being made to establish relationships of trust, to establish relationships of equality, and to give as well as to take from residents.

10. The depth semi structured interview was the main research tool used for the qualitative research. 30/40 residents and adjacents (a small number of people in adjoining streets) were interviewed on each estate, and 10/15 professionals on each. Selecting people to interview was grounded in participatory observation and through contacts , and through 'selective snowballing'. An aim was to produce a broad coverage of active and non active residents, and respondents who

reflected the socio-economic and demographic make up of the neighbourhood.

11. Interviews with residents included questions which explored their perceptions and changing perceptions of their neighbourhood, coping strategies to deprivation adopted, the characteristics and structure of social networks, the support given and received, participation in formal and informal organisations, their attitudes to the wider society, and their hopes and aspirations for the future. Questions on health referred to their current self- assessed health status, and in addition respondents were asked to reflect on their life and health history, and to comment on the factors which they believed were important in influencing health and well being. Health means something more than is captured in morbidity measures.

12. Interviews with professionals focused on their perceptions and experiences of the neighbourhood.

13. An understanding of peoples social networks is an essential feature of this research. Semi structured interviews can provide information on network structure and the characteristics of the people in the network, as well as the benefits which networks provide without resorting to the precise measures and techniques adopted by network analysts.

14. Grounded theory methodology was utilised to analyse interview data. Bott's concept of membership groups was adopted as an aid to developing typologies. Membership groups provided a way of bringing together characteristics, structures and functions of networks for analysis, and her concept of reference groups was useful when considering aspects of solidarity, of people's attitudes towards others. Models were constructed based on the membership groups which made up the network.

6. THE LEA VALLEY: A SOCIAL, ECONOMIC AND HEALTH PROFILE

Introduction

Communities, in the sense of smaller localities, but also in terms of social interactions which take place there, and perceptions held by residents, exist in space, time and social and economic structure. These to some extent make constraints on or shape community life.[1] The local communities selected for the case studies are located spatially in the Lea Valley region of East London. This chapter looks briefly at relevant aspects of the region's history and at its economic structure. It then goes on to investigate the region's social structure in terms of socio-economic characteristics of its residents, their employment patterns, and levels of poverty and deprivation in the area on a range of measures. It ends with an examination of health indicators in four of the region's boroughs and of local health policies.

In addition, Chapter 3 posed the question: 'How can we account for the differing health experience of Londoners compared to other deprived areas?' A number of possible explanations were suggested including some which centred on issues of timescale and measurement. This chapter considers whether:

(i) London's (or at least East London's) worsening deprivation may yet be reflected in the Capital's mortality rate, London may yet "catch up" with areas whose experience of deprivation, unemployment and poverty have been more long term.

(ii) Different deprivation variables may have different meanings for the health of the population in London compared to elsewhere.

(iii) There may be important differences between the demographic profile of Londoners compared to elsewhere.

(iv) We may be missing something connected with the spatial patterning and measurement of poverty, such as issues connected with concentration and isolation.

(v) A good level of provision of health and other services may be having an effect

The analysis does not cover the whole of London - the Capital's diverse and extensive population make London-wide comparisons unwieldy.

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1 See for example Bulmer, 1986; Giddens, 1984

The context

Six adjacent boroughs in East and North London together make up the Lea Valley Region Four are part of inner London: Hackney, Haringey, Newham, and Tower Hamlets. Two are in outer London: Waltham Forest and Enfield. There is no clear and obvious delineation between the boundaries of the East End, East London, and North London. As the late David Widgery put it:

> "The 'old' East End was compact, stretching from Jewish Whitechapel through Stepney to the Poplar docks: a long gone world of intimate terraces... Most East Enders themselves would include Bow, Bethnal Green and Hoxton to the north and at least part of Newham to the east. Quite where East London cedes to North London is difficult to decide: usually the line of the ancient northbound Kingsland Road which slices north from the city through Hackney and Stoke Newington is taken as the dividing line. The border is still more difficult to define in the east where a long working-class residential corridor stretches through Stratford and Barking out to Dagenham and Cockney Essex."
>
> D. Widgery, Some Lives: A GP's East End, Simon and Schuster, 1991. p 29

London itself is often described as a city of contrasts, where affluence and deprivation are said to live side by side. For the Government Office for London, for example, contrasts take the form of needs in one part of the Lea Valley region, and opportunities in the other: "it [East London and the Lea Valley] comprises communities which have long been associated with urban deprivation - Whitechapel, Bethnal Green, Hoxton; and districts which have been the driving force behind the Capital's economy - from West Ham, through Stratford, and north along the Lee Valley to Hackney Wick, Walthamstow, Tottenham Hale, Edmonton, and Enfield." (Government Office for London, 1994, p.3). The contrast between the East End on the one hand, and the rest of the region on the other may be exaggerated, but historically patterns of emigration followed a certain pattern. The Government Office for London continue: "From the 1800s to the 1970s, East Londoners looked to the opportunities along the Lee valley to provide them with jobs, a better standard of living, and the chance of migrating from districts tarnished by a legacy of poverty". (Government Office for London, 1994, p.3).

The reasons for uprooting themselves, however, were perhaps for some as much social as economic. Young and Willmott described the traditional route taken by Eastenders desirous to escape the poverty of the East End and move 'up in the world'. People would migrate from the East End (Bethnal Green or Poplar) to Hackney, Walthamstow or Leyton, then through to Chingford or Woodford - the latter securely out of London altogether, and 'under Essex' (Willmott and Young, 1960). A somewhat different process had occurred in Hackney a little earlier, at the turn of the century. Here, the state of its housing has, it has been argued, played no small part in shaping the borough's character. "Hackney is becoming poorer' wrote Booth in 1900, 'The larger houses are

turned into factories. The better to do residents are leaving or have left ... Each class as it moves away is replaced by one slightly poorer and lower'. '... Dirty, shiftless, helpless and undisciplined, but not criminal, they lack the sturdiness of offenders and are rather to be described as crushed and downtrodden ... We are told that those who can and do improve, leave". (Booth, 1902-3).

The opportunities open to East Londoners for (upward) social and geographical mobility are not what they were. Walthamstow and Leytonstone are unlikely to provide, as they did for a man in Young and Willmott's case study,[2] and for many like him - a stepping stone on the traditional route out of poverty. The Regional office for London, commenting on the pioneering spirit of the region, were moved to observe: "Inside a generation, these opportunities have collapsed. The recoil in East London has been felt in long term unemployment, alienation and social exclusion" (Government Office for London, 1994, p.4).

Not all chose to take these routes out of course, and it would be wrong to think of East London as a place where people (Booth's "shiftless", perhaps) lived only if they lacked the opportunity to escape it. Most stayed, and appeared content to do so, particularly at times when jobs were plentiful. The Bethnal Green of Young and Willmott is a part of London now always to be identified for its patterns of close knit networks of kin and for strong community loyalties. Young and Willmott explained its characteristics in terms of stability of employment. In the 1950s, Bethnal Green had many industries to lean on (Young and Willmott, 1957).

The downside to the varied local economy of East London was that many of its industries were small scale. The small scale traditional crafts of East, and parts of North London - clothing footwear and furniture - were characterised by "sweating".[3] It is a process which is said to continue still in Hackney's rag trade (Harrison, 1983). There have, of course, been better paid jobs in the region. The Royal Docks in Newham for example were a plentiful source both for skilled and unskilled employment until containerisation in the late 1960s and early 1970s precipitated their decline, and some larger scale factory units were to be found in Enfield and Waltham Forest at this time. However, official estimates suggest that thousands of jobs were lost in the Docks and manufacturing in the 1970s and early 1980s (Government Office for London, 1994).

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2 See Willmot and Young, (1960, p.15)

3 This involved attempts to reduce overheads to a minimum by, for example, resorting to such measures as using cramped premises or employing homeworkers, and paying subsistence wages (Stedman-Jones, 1971).

Recent downturns in the economy and the gradual erosion of the area's manufacturing and industrial base (explored later) are not the only factors which have been seen to have had a negative impact on the lives of East London residents. Town planning of the 1950s and 1960s may have adversely affected the quality of peoples lives. For Titmuss, writing in 1957, slum clearance, and the relocation of East Londoners into out-of-town estates had ruined many of the positive aspects of the area, essentially, its sense of community (Titmuss, 1957). Described as "a village where everybody knew each other ... and looked after each other" (Widgery, 1991,p.7) Bethnal Green is fondly remembered by a GP colleague of Widgery's who worked in the area before redevelopment. "The old terraces" argues Widgery, "may have been unhygienic, but they provided endless locations for social intercourse, gossip, courtship and news gathering ...[while now] tower blocks froze people into well upholstered isolation" (Widgery, 1991). Widgery adds: "I'm watching something die and I wish I wasn't" (Widgery, 1991, p.38).

The Lea Valley: people, employment, poverty and deprivation

London's Other River (Cattell, 1997) compiled as part of the work undertaken towards this thesis, is a comparative demographic, economic and social profile of the six boroughs which make up the Lea Valley region, All of the features examined - socio-economic characteristics; household composition, housing conditions and tenure, job loss, unemployment, low income and deprivation, have been shown to play a major role in the patterning of health inequalities. The following discussion on implications for health is based on the evidence considered and conclusions reached in the report. A list of sources used is included in the Appendix.

Socioeconomic Characteristics.

Lea Valley boroughs tend to have populations which are relatively young, with a high proportion of children. Five Lea Valley boroughs are amongst the most ethnically diverse in the country, the exception is Enfield. These are working class boroughs. All Lea Valley boroughs except Enfield have much higher proportions of residents in social classes IV and V than the London average, and all except Haringey are under-represented in terms of the top classes.[4] There is evidence, however, that the proportion of people in social classes IV and V - semi skilled and unskilled - has declined

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4 Haringey can be described as the most professional and middle class of the six boroughs, and Hackney the most polarised in class terms. There are relatively high proportions of the skilled non manual and skilled manual classes in Waltham Forest and Enfield, skilled and unskilled manual workers in Newham, and semi skilled and unskilled in Tower Hamlets.

quite dramatically in the Lea Valley between 1981 and 1991 Censuses. One of the objections raised to the Black Report, as we saw in Chapter 2, was that the worst mortality rates were found in an ever-shrinking section of the population. Yet in 1991 there were a high proportion of Lea Valley residents in the "inadequately described or no job in the last ten years" Census category. Former unskilled workers are not likely to be taking up skilled or professional jobs in the Lea Valley. They are unemployed or have been absorbed into the uncategorised class of official statistics. Statistical exclusion is unlikely to benefit their health. Indeed Standardised Mortality Ratios for the area based on the Registrar General's scale of social class is likely to underestimate health inequalities for the region, in that the "unclassified or no job in the last 10 years" census category is usually omitted.

The economy and unemployment

Other services and hotels, distribution and catering dominate the local economy. These sectors are the most likely to provide low paid and part time jobs. There are implications for health in terms of low pay, possible job satisfaction or its lack, and certainly insecurity, but these would need further investigation.

Dramatic increases in unemployment in London during the 1980s and earlier part of the 1990s have had a disproportionate and devastating effect on Lea Valley boroughs. Some have the highest rates of unemployment in the country, and some have the highest rates of growth in unemployment in the country. The young, ethnic minorities, and residents from skilled manual, semi-skilled and unskilled classes - all of whom are well represented in the region, are especially at risk, as are the many residents who worked in sectors or in occupations which have undergone decline. When and where several of these categories combine - as they do in the region's Inner City districts but also in other parts as well - the individual is in a multiply disadvantaged position. The implications for health of multiple disadvantage are clear (see Chapter 3). The disproportionate growth in unemployment locally is potentially particularly significant for health outcomes. Poverty, insecurity, the anomie associated with rapid social change, and curtailed social networks, are all potential mechanisms. Evidence on the disproportionate growth in long term unemployment could suggest that any upturn in the job market could have limited positive impact on health as the long term unemployed are less likely to regain employment than those who are unemployed for a relatively short time. Long term unemployment - (along with worse mortality rates) - was until recently a feature more usually associated with the North of England than the South.

One of the questions posed in this research was whether there are factors operating in a locality over and above the socio-economic characteristics of residents which could impact on health. Some of

the evidence considered on the economy is interesting here. There was an apparent disjunction between the nature and availability of local jobs and the employment and unemployment patterns of residents. High rates of unemployment co-existed with economic growth and expanding job opportunities. Tower Hamlets, and to a lesser degree Hackney and Newham, have relatively buoyant economies and job growth in certain sectors coupled with some of the highest unemployment and inactivity rates in the country. Good local jobs are not going to local residents. Earnings and income data re-inforce the general point, particularly in relation to Tower Hamlets and Hackney. Here there is an evident mismatch between relatively high levels of work based pay together with low proportions of low paid workers on the one hand, and the exceptionally low income of many local residents on the other. If, as the evidence suggests, there is in East London a growing divide between the economic position of employees - many of whom will come in from outside - and of residents, then we might expect *perceptions* of inequality amongst residents to be particularly acute. As we saw in Chapter 3, perceptions of inequality are thought to have an adverse effect on health.

Poverty and deprivation

Causal factors associated with material deprivation and implicated in health inequalities - poor housing conditions and overcrowding, unemployment, and low incomes- are dominant features of the region. There can be little doubt that the Lea Valley contains boroughs which are the poorest and most deprived in England. Overcrowding and homelessness are major problems for example, and a high proportion of children are living in 'unsuitable accommodation' that is flats, non self contained or non permanent accommodation in all Lea Valley boroughs except Enfield. When *composite* indices of poverty and deprivation are examined, the disadvantaged position of Lea Valley boroughs - especially East London boroughs - is thrown into even sharper relief. The Index of Local Conditions identifies Newham as the most deprived borough in England; Tower Hamlets is ranked as the most deprived borough in England on each of two alternative indices examined, and Hackney takes second place. Sensitive measures adopted by the Index of Local Conditions suggest that extreme deprivation is more widespread across Tower Hamlets and Hackney than it is anywhere else in the country, and that Tower Hamlets contains pockets of deprivation at ward level which are the worst in England. Moreover, when we consider the most deprived fifth of all London wards, then approaching half (43%) of London's "worst" wards are concentrated in five of the six boroughs.

On whatever approach is adopted - local income surveys, Census proxies for poverty and wealth, statistics on benefit recipients and benefit entitlement - estimates suggest that residents' incomes

are very low across much of the area. In some places they are the lowest, or amongst the lowest, in Britain. The Lea Valley contains high proportions of groups identified nationally as at risk of low income poverty. Families with children (including single parents), the unemployed, those economically inactive, (including the permanently sick), and benefit recipients, are the most important of these. High proportions of families with children are living on low incomes in the region for example, as are high proportions of social tenants. Local surveys suggest that difficulties are encountered by those who must struggle to manage on a low income. We would expect health indicators to be poor for both adults and children in the region.

One of the themes in this thesis is whether 'concentrated poverty' is a useful concept to capture and describe the many features of poverty and deprivation, and whether there are health implications. Are health problems exacerbated for example, in 'concentrated poverty' areas? There is some local evidence of both a widening of inequalities between income groups on the one hand, and an increasing spread of poverty or the risk of poverty on the other. Data considered on car access points in the direction of increasing polarization of income groups, and of some widening of geographic inequalities within boroughs. The latter may be a reflection of national urban trends towards an increasing concentration of the poor and deprived in certain locations, usually the less popular housing estates (see Chapter 1). A disproportionately steep increase in the incidence of long term unemployment suggests a hardening of unemployment trends in the Lea Valley. Very low proportions of two earner households locally not only reflect the national tendency towards a growing divide between work rich and work poor households, but clearly illustrate the distinct spatial patterning of these trends. Growing inequalities on the national scale impact sharply on areas which are already highly disadvantaged. Taken together, these patterns are perhaps indicative of some consolidation in social and spatial dimensions of poverty.

Other indications however, are illustrative of the increasing spread and a changing profile of those in poverty. Although the likelihood of experiencing unemployment is highest in all six boroughs for the skilled manual, semi-skilled and unskilled classes, there are nevertheless quite high proportions to be found in the professional, administrative and managerial groups. Council tenants are poorer as a group than they used to be, but so are some home owners and a relatively high proportion of local residents appear to be facing problems in meeting mortgage payments. Getting into debt, or struggling to avoid it, is, as we have seen, detrimental to health. Spatial divisions, cannot be easily drawn either, at least at the borough scale. Although residents of Tower Hamlets, Hackney and Newham can readily be identified as the most disadvantaged in England, the fortunes

of Lea Valley boroughs cannot be split into East London on the one hand, and the more northerly boroughs on the other. Unemployment grew more steeply in Haringey during the 1980s, for example, than anywhere in the country, and some of the jobs located in the borough pay extraordinarily low wages. Waltham Forest experienced a sharper rate of increase in unemployment in the 1991-95 period than any of the remaining five boroughs, and job based pay in the borough is the lowest in London. Waltham Forest's role as a stepping stone on the traditional route out of poverty is now slippery and uncertain.

We might expect to see a worsening of health in the poorest groups and the poorest areas, but also a worsening spread of health in not so poor groups and areas, other things being equal. This would require a detailed statistical analysis beyond the scope of this research. Although the evidence here is unable to tell us about health, it indicates that concentrated poverty is certainly not the only way of looking at the incidence and growth of poverty locally. Measurement issues take this point up more fully.

Issues of measurement and selection of variables

Selection of variables

It was stressed earlier that it is important that the deprivation indicators selected for composite indices of deprivation do accurately and adequately reflect the experience of areas. Different indicators, for example, may have different meanings for certain areas, and may help to explain anomalies in area based health inequalities, including the anomalous position of London compared to other deprived areas. Some of the following comments refer to evidence in the Deprivation chapter of *London's Other River*, and which is reproduced in appendix 5. The remainder refer to poverty statistics in Green's 'The Geography of Poverty and Wealth' (Green, 1994).

Table 23 in *London's Other River* (see Appendix 5) indicates the range of variables used in 4 deprivation indices. When Lea Valley boroughs are compared on different deprivation indices some interesting patterns emerge. In relation to Haringey, Enfield and Waltham Forest, the rankings produced by the Townsend Material Deprivation Index (Town) and the Index of Local Conditions (ILC) are not at all dissimilar, while rankings on the Social Deprivation (Soc Dep) and the Poor Indexes also show a close similarity in all three boroughs. The first pair of indices include only direct measures of deprivation, and not population groups at risk of deprivation. The second pair of indices, that is the Social Deprivation Index and the Poor, contain both indicators of groups at risk and more direct measures, with, in the case of Social Deprivation, groups heavily outnumbering

direct measures.

Town and ILC have three variables in common: no access to a car, unemployment and overcrowded accommodation. The fourth, and remaining variable on the Town Index, not in owner occupation, bears comparison with one of the remaining ILC variables, children in unsuitable accommodation. The Index of Local Conditions however includes a further 9 variables. The similarities on the rankings produced by the narrower and the much wider deprivation index would suggest (according to this admittedly very limited and perfunctory analysis) that the Townsend measure is an adequate summary measure of deprivation, at least in relation to the boroughs under consideration.

The Social Deprivation Index and the Poor index, which display similarities in rankings for Haringey, Waltham Forest, and Enfield, have three variables in common - unemployment, long term limiting illness and lone parenthood. The remaining variables included in Soc Dep - youth unemployment, single pensioners, and dependents in the household, are all likely to be associated with social deprivation (or relative non participation in the community) while those extras in the Poor Index, - unskilled workers, no access to a car, and not in owner occupation - are all factors which we tend to associate with material deprivation. The similarity in rankings on this pair of indices for four of the boroughs might be a reflection of some inter-correlation between material and social deprivation, but this would need further investigation. Work reviewed earlier suggested that the impact on health of both material and social deprivation was always greater than the effects of each alone. Again, we would expect health indicators to be poor in these four boroughs.

The case of both Newham and Tower Hamlets, however, would appear to discount tentative inferences drawn from these observations on intercorrelations of deprivation indices. Newham is ranked first on the Index of Local Conditions, but sixth on Town, 10th on the Social Deprivation Index and 11th on the Poor. The differences between the rankings for Newham on Town and ILC may be indicative of the ability of the more complex measure (ILC) to uncover aspects of deprivation which the more summary measures are not able to. Newham may be more "multiply deprived" than adjoining boroughs, but less deeply deprived than Tower Hamlets and Hackney on those measures which collectively make up the Town material deprivation index. Newham has a relatively high proportion of households on some of the additional ILC variables - lacking basic amenities was one of these. Alternatively, we may prefer to view the ILC as a more valid representation of deprivation as a whole, but the Town index as a more accurate tool for uncovering levels of income-related poverty. Given the close association between material deprivation and social deprivation evidenced in research reports (Townsend, 1991; Blaxter, 1990; Benzeval et al,

1992), Newham's better than expected rankings on Soc Dep and the Poor (both of which include social deprivation variables) suggests perhaps that there may be some substance to these assumptions concerning Town. But, that Newham's contradictory position on different indices may turn out to be a simple statistical artifact cannot be ruled out.

Tower Hamlets, not surprisingly, given its top rankings on individual proxy poverty measures, is ranked 1st on Town, 1st on The Poor, but 5th on Social Deprivation and 7th on the Index of Local Conditions. Town and the Poor have three variables in common - no car, not owner occupied, and unemployment, all factors associated with low income.

It should be stressed that too much weight should not be attached to these observations. The differences between the proportions for individual boroughs on any one index can be very small, and it would be foolhardy to read too much into them. Yet, differing rankings on deprivation indices for any one of the Lea Valley boroughs make sense when the variables utilised by each measure are related to the borough's profile on individual variables. Such internal consistency would suggest that intra-borough differences in rank order on deprivation indices *can* in large part be explained by the selection of variables for the composite measure. What can be said with some certainty, is that whichever of the four major deprivation indices examined here is selected, Lea Valley boroughs - with the exception of Enfield- do badly, and three do very badly indeed.

Measures at different spatial scales

It was suggested earlier that different measures of poverty at different spatial scales may have implications for the amount of poverty and deprivation found, and that this, in turn, may contribute to an understanding of why some areas have anomalous health indicators.

The ILC has made available different measures of deprivation relating to different spatial scales. When applied locally, they indicate some interesting intra-borough variation. Table 25 in Appendix 5 indicates borough values by rank, degree, extent and intensity. For example, Tower Hamlets contains some of the poorest wards in England, yet its ranking falls on the degree or overall measure indicating that the borough is likely to contain pockets of relative comfort as well. Interestingly, although Newham is the most deprived borough in England on the ILC, the 3 most deprived wards in Waltham Forest are more highly deprived than Newham's worst 3. One of the Waltham Forest wards is Cathall, the location for one of the case study estates.

These observations, together with those on selection of indicators, suggest that the selection of deprivation indicators and the spatial scale adopted do make a difference to the amount of poverty

identified within an area. This does not mean however, that intra- or inter-borough differences are simply a statistical artefact. Lea Valley boroughs are highly deprived according to a range of indicators and at a range of spatial scales. However, there are implications for discourse on 'concentrated poverty'. When attempts are being made to identify an area as one of concentrated poverty, the spatial scale adopted or the variables selected will have implications for the amount of poverty so found.

Comparison of Lea Valley boroughs on Green and the ILC illustrate these issues more clearly. The Index of Local Conditions maps the distribution of deprivation in England. "The Geography of Poverty and Wealth" (Green, 1994) facilitates the comparison of London boroughs with Great Britain as a whole and adopts a similar three tier approach to spatial measures as the ILC. Green's data, unlike the ILC which used a number of official statistics as well as Census data, are wholly restricted to the Census of Population.

In addition, Green's report focused on individual variables associated with poverty and wealth rather than wider approaches to deprivation or composite measures. Because other research had shown that three key correlates of low income are no car, no owned home and no job, proxy indicators relating to them and to social class were utilised: unemployment rate, households without access to a car, rented accommodation, inactivity rate, and economically active in semi- skilled, unskilled and no occupations. Like the ILC, Green's analyses of Census data are presented for three measures of spatial distribution: degree, extent and intensity: Only the extent measure differs from ILC usage, where extent refers to the proportion of EDs falling within the worst 7% in England.

Green's results on the intensity measure are interesting and show some similarities but also some diferences with data examined so far. In many of the largest cities in Britain it was the localised intensity of poverty (that is the mean of the worst three wards) which was found to be more marked than its degree or extent. Green noted for example that many of the intense pockets on the unemployment and non car poverty indicators for example are found in the North and North West of England and in Scotland. Intensity on these measures is less marked in London, but increased markedly during the 1980s.

Visible differences in scores for the intensity measure on individual poverty measures compared to the more familiar degree and extent are quite startling for Lea Valley boroughs. They help to illustrate more clearly some of the measurement issues already discussed. Although Hackney, not unexpectedly, ranked 1st in Britain in 1991 on both the degree and extent of *unemployment* for

example, on the intensity measure the borough drops to 15th place. Unemployment in Hackney may be more widespread than anywhere else in Britain, but the worst *pockets* of unemployment are not found in Hackney. Sharp differences between the intensity and both remaining measures are also evident for Tower Hamlets, Newham, and Haringey. Newham for example was ranked 5th on the degree of unemployment in 1991, but 26th on intensity.

Similarly, when we consider the *no car* poverty measure, a certain amount of slippage is evident between the rankings on the degree (value for an area) measure and those on the intensity (mean of the three highest ranked wards) for all four Lea Valley boroughs featuring in the top 15 rankings on degree. Discrepancies on rankings range from a difference of 16 places in the case of Newham, to 31 places in Haringey.

Hackney and Tower Hamlets are the only Lea Valley boroughs to feature in the top 15 *households in rented accommodation* rankings on degree for Great Britain. Tower Hamlets' position at 14th place on the intensity measure is, at face value, somewhat unexpected and surprising given the borough's premier place in the country for the proportion of its households living in rented accommodation. It may less surprising however if we compare the housing patterns and spread of tenures in the borough with some of those found in Districts in the North, North West of England, and Scotland. Vast periphery housing estates (which, by definition are not features of the Inner London landscape) may well, in some Northern boroughs, spatially dominate a ward. Estates like Meadowell in North Shields, Hulme in Manchester, Easterhouse in Glasgow, are three examples. In Tower Hamlets the scale of individual housing developments are smaller, and the resulting tenure patterns - at ward level - slightly more mixed. Glasgow City, which is Tower Hamlets alter ego North of the border on many a proxy poverty indicator, is, incidentally, ranked first in Britain according to the intensity, or score of the highest ranked 3 wards, of its rented housing.

Literature reviewed in Chapter 1 suggested not only a greater likelihood for people living in rented housing to be unemployed, living on low incomes etc., but that this is a process which has intensified in recent years. More of those who are poor live in the social rented sector than in owner occupied homes. Very high intensity scores for boroughs in the North and Scotland at the *individual ward level* are in a sense, reflections of these associations writ large. Where a ward contains a sizeable, or several housing estates, then there are likely to be a large number of poor people living in that ward. Tower Hamlets for example, may contain a higher proportion of poor households across the borough than say a given Northern borough, but the Northern borough may have a higher concentration of poor households living in one or two individual wards . Conversely, an East

London borough may well (or may not) have worse levels of poverty at a smaller scale of analysis than the ward, an estate for example. The spatial scale adopted will clearly have a bearing on the amount of poverty found. The existence of the large scale periphery housing estate, which is a feature of parts of the North and Scotland, but not inner London, and which may be characterised by a tendency to social homogeneity (like Easterhouse) over a relatively wide area, will, if these assumptions have any substance, be having an affect on observed intensity measures on a range of poverty indicators, and not just those which relate to housing tenure.

The spatial scale adopted will have relevance for poverty measures and may also have possible implications for unexpected variations in London's health relative to other deprived areas, but this would need more thorough examination. However, Easterhouse is a large scale housing estate in Glasgow which has been identified as having a disproportionately high infant mortality rate, (Goodwin, 1995)

What this analysis does show however is that 'concentrated poverty' may not a useful concept to use with structural analyses, and much depends on how large or small an area one would label as 'concentrated'. The Lea valley area is better described as one where poverty and deprivation are widespread and where residents are multiply deprived.

Are there other deprivation indicators which provide evidence of 'concentrated poverty' in the Lea Valley? Green is interested in aspects of segregation, in particular, with a measure of 'isolation' which refers to the extent to which sub-group members are exposed only to one another. Arguably, this is also a measure of 'concentrated poverty'. The measure also has possible implications for the density of social networks. Green ranked the top 15 Local Authority Districts on an *index of isolation* using several poverty indicators. "The index of isolation measures the probability for a member of a sub-group that someone else randomly chosen from the same area will be a member of the same sub-group" (that is, it measures the extent to which members of a sub-group are exposed only to one another) (Green 1994, p.85). Northern Britain dominates the rankings on this aspect of isolation, but some London boroughs, including Tower Hamlets, Hackney, Islington and Southwark feature in the top 15 in 1991 on several of the indicators, but not all. Tower Hamlets was ranked 2nd (after Glasgow City) on the no car isolation indicator (that is the extent to which those without cars are likely to be exposed locally to the similarly poor and immobile), and Hackney 3rd. Newham experienced the greatest *increase* on this measure during the 1980s. On the unemployment isolation measure, Hackney was ranked 4th in Britain, Tower Hamlets 5th, Newham 8th, and Haringey 11th. When comparisons were made for 1981, it was the increase in the isolation of the

unemployed which was particularly marked in Inner London. Haringey was ranked first in Britain on this measure, Hackney 2nd, Tower Hamlets 3rd, Newham 4th, Waltham Forest 10th and even Enfield, ranked 11th, showed a sharp increase in the 'isolation' of those without jobs. On the isolation of rented households index, Tower Hamlets was ranked 1st in Britain, and Hackney 3rd.

Where do the mainstream live?

Green's measure of isolation is in a sense, a measure of concentration. It is concerned with the extent to which the poor are cut off from more "mainstream" groups. More traditional approaches to isolation are generally broader, and focus for example, as we have seen, on restricted social networks and lack of integration into the community (see Chapters 3 and 4). For House, for example, social isolation is the absence of social contacts (House, 1988). It is difficult to judge the significance of Green's concentration measures over and above the results obtained for the straightforward no car, rented housing or unemployment census measures. They certainly indicate evidence of relative isolation or separation of the poor in the Lea Valley from the better off, the better housed, and those with jobs. But that is all: they do not tell us anything about social isolation as a lack of social integration, at least not at the level of the individual. They do not tell us about social deprivation, about lack of normal participation. An unemployed resident of Tower Hamlets for example, may, or may not, have many similarly unemployed friends, family members, and neighbours in the vicinity. She or he may also, or may not, have networks which stretch across local and national boundaries. Green's measures do have significance however for the potential characteristics and structure of residents social networks. The increased chance of residents being exposed to people similar to themselves - in terms of unemployment, poverty, tenure, for example, will restrict the potential membership groups available in an individual's network. There are also implications for the growth of values which may or may not differ from those of the 'mainstream', particularly those which may impact on health. Given the importance of social networks to health then concentration/isolation measures are very likely to have relevance for health. Proper investigations however, would need to be of the rigorous survey kind. In the meantime, the dissimilarity and similarity of people's social networks is explored qualitatively in the chapters on local case studies.

The weight we attach to isolation statistics will be related to how isolation is conceptualised. Is it the isolation of the individual from the 'community' - in either the local neighbourhood or interest group sense - which is important, or the isolation of the poor as a group, living in an area of concentrated poverty, and cut off from the mainstream? Who are the mainstream, and where do they

live? Who would the mainstream consist of for the Tower Hamlets resident? People in the next ward perhaps? But they are quite likely to be unemployed themselves, living in rented accommodation and on low incomes. Then the next borough maybe? Unfortunately the next borough is Hackney on one side, and Newham on the other, boroughs with widespread, extensive, poverty, deprivation and unemployment. Perhaps the mainstream are living comfortably in nearby outer London boroughs, but Waltham Forest and Enfield have not escaped the general London trend of rising unemployment in the 1980s and early 1990s. Regrettably Haringey is no safe haven either, here unemployment rose more steeply during the 1980s than in anywhere in the country. We could of course take the large chunk of London represented by the six boroughs and label it a "concentrated poverty" area, but this would be stretching the limits of spatial and conceptual flexibility too far. Again, the area is better described, as became clear from analysis of data using *extent* measures, as one where poverty and deprivation are widespread.

Health data examined below are unable to get at any of these complex issues concerning poverty and deprivation variables, spatial measures, and isolation measures, and their relevance to health. It can however, by examining the health profile of local boroughs and parts of boroughs, confirm or deny the link between deprivation and health at the local level. It can also address the explanation for London's anomalous position suggested earlier, that London's health experience may yet catch up with deprived areas elsewhere as poverty and unemployment become more entrenched.

HEALTH IN FOUR LEA VALLEY BOROUGHS

Part one of this thesis looked at literature on health inequalities largely at the national scale. This present chapter has analysed data on poverty and deprivation for six London boroughs. Now, Russian doll like, the next layer of research considers health data available for two health authorities within the Lea Valley region: East London City and Hackney Health Authority (Elcha) and Redbridge and Waltham Forest (R&WF). Census statistics considered so far identified three Lea Valley boroughs as the most deprived in England - Tower Hamlets, Hackney, and Newham, and an adjacent borough - Waltham Forest as having high levels of deprivation in its southern half. The first three boroughs are in the Elcha district, the fourth in Redbridge and Waltham Forest. Important questions put to the data include:

1) To what extent is the extremely poor and derived profile of the area reflected in poor health standards?

2) Does the data confirm that class, poverty and ill health are inextricably linked?

3) Is there evidence to suggest that health standards are worsening locally?

4) Can local evidence indicate whether London's Health has 'caught up' with that of similarly deprived areas elsewhere in the country but whose experience of poverty and unemployment has been of longer duration?

5) To what extent are Health Services able to protect the health of local populations?

Measures of health and illness utilised included mortality statistics; statistics on long term limiting illness, hospital admissions, registrations,[5] GP consultation rates, and data based on self assessment surveys. The availability of accurate and complete local morbidity data in Britain is limited.

Deprivation and health

Both health authorities recognise the importance of poverty and deprivation in structuring health chances. As Elcha put it - "If there were one magic bullet that could transform health in the East End...it would be to reduce the extreme poverty experienced by most East Londoners" (Elcha, 1995,p.3) . Tower Hamlets and Hackney rank as the top two deprived boroughs in London on the Jarman index, (Elcha, 1995). In Waltham Forest raised Jarman scores are found predominantly in the South of the borough, particularly in the Leyton and Cathall wards (R&WF HA, 1995). An alternative index by Newchurch and Company for the Redbridge and Waltham Forest FHSA produced similar results.[6]

Although mortality rates are falling in London, as they are elsewhere in the country, in London they are not improving to the same degree. Standardised mortality ratios (SMRs) are worsening for London, and especially for inner London (LRC, 1996).[7] Evidence for London confirms evidence

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5 Registers are kept for certain disorders - notifications of infectious diseases and congenital malformations and cancer registrations.

6 A specific care demand index was calculated using variables covering Long Term Limiting Illness (LTLI), over 85 and living alone; overcrowded household; permanently sick or disabled aged 50-64; two or more people aged 75 or more; lone parent aged under 25; household with child/children under 5; long term unemployed; ethnic minority born overseas; households without amenities. Much of Walthamstow and Leyton were found to have scores (24%) substantially above average (R&WF HA, 1995).

7 Comparison of mortality rates at local level with national rates is generally expressed as a standardised mortality ratio (SMR). This ratio is derived by taking the observed number of deaths in a district over a given time period and dividing it by the number of deaths that would be expected if national rates applied. The ratio expresses the local mortality rate as a "percentage" of the national rate after allowing for differences in age and sex distribution.

from national studies, that is that area based health inequalities appear to be widening. Some - though not all - of London's most deprived wards in 1981experienced the largest increases in SMRs in 1991 (LRC, 1996). At the local level raised Jarman scores[8] indicate the area's worsening position. The scores for Newham and Tower Hamlets have worsened significantly since 1981 - by 25% and 16% respectively (Elcha, 1995). Tower Hamlets has the highest proportion of residents in London classifying themselves as permanently sick. Between 1981 and 1991, there was a 48% increase amongst men and an 189% increase amongst women in the borough. (London Borough of Tower Hamlets, 1994).

Table 1: Standardised Mortality Ratios, London Boroughs, 1991.

	All Age	Under 75	Under 65
Hackney	110.5	123.9	132.2
Newham	109.5	120.6	120.0
Tower Hamlets	110.5	123.0	132.5
Waltham Forest	97.5	103.6	102.9
Inner London	104.8	115.1	123.0
Outer London	93.0	92.3	91.5
Greater London	97.1	100.4	102.9

Source: London Research Centre, The Capital Divided, 1996, based on OPCS statistics.

The most deprived London boroughs tend to be those with the highest mortality rates. All four Lea Valley boroughs examined have higher SMRs than the average for London as a whole. These London boroughs do not seem to be in an anomalous position as far as their health is concerned. Of course, death rates are not an entirely satisfactory indicator of ill health. Morbidity data however confirms the poor position of the four boroughs. The question on long term limiting illness (LTLI) in the Census measures people's own perceptions of their health. The rate for LTLI for London was slightly lower in 1991 than for the country as a whole, but there were wide disparities between inner

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(Elcha,1995). The all age SMR for Newham in 1991 for example was 109.5, indicating that the rates in Newham are, on average, almost 10% above the equivalent national rates. The SMR for England and Wales is 100. SMRs for London as a whole are 2 per cent lower than the national average. (LRC, 1995).

8 Jarman scores are described in Chapter 5

and outer London (LRC, 1996). Perhaps such evidence is indicative of a 'two Londons' effect for health. Attempts to aggregate statistics for London as a whole can be misleading, and contribute to the identification of the anomalous health situation of London claimed in parts of the literature.

Proportions of residents with a limiting long term illness as a percentage of all persons are higher in all four boroughs than the London average, (OPCS, 1991 Census, Crown Copyright). Hackney has the highest rate of LTLI in Inner London, at 14% of the population. Proportions in Tower Hamlets and Newham are also very high. The London Borough of Waltham Forest calculated that local rates of LTLI were far higher for all ages than those of the OPCS National Disability survey conducted in 1987-89 (R&WF HA, 1995). Rates also vary by gender, ethnicity, tenure, employment status and social class (Griffiths, 1994; R&WF HA, 1995; Mori, 1993). Local surveys suggest that more than a third of council and housing association households in Newham for example contain someone with a disability or LTLI (Griffiths, 1994). Residents with LTLI are more likely to live in households where no one is

Table 2: Residents in households: limiting long-term illness, London boroughs, 1991.

	Standardised Ratio	%
Newham	124.4	13.0
Tower Hamlets	125.2	13.6
Waltham Forest	103.7	12.1
Inner London	110.1	12.3
Outer London	89.1	10.7
Greater London	96.6	11.3

Source: London Research Centre, The Capital Divided, 1997. Based on OPCS 1991 Census.

Note: The standardised illness ratio shows local prevelance of LTLI as a percentage of national prevalence after allowing for differences in the age and sex structure of the local population.

in work. In Newham for example, 44% of those of 16 years - retirement age fall into this category, (Griffiths, 1994) while in Waltham Forest Census data shows that 62% of households with someone with a LTLI did not have an adult in work compared to 35% of all households (London Borough of Waltham Forest, 1995-96) A Mori survey of residents in the East London and the City Health

Authority District found social groups D and E (semi-skilled and unskilled) to have higher rates of LTLI, in line with general household survey findings for the country as a whole. (Elcha, 1995).

Rates of long term limiting illness vary geographically within boroughs. In Waltham Forest for example, they appeared to be higher than average in Walthamstow and Leyton, (the more deprived half of the borough) and below average in Chingford (R&WF HA, 1995). At the ward level, differences can be stark. In Tower Hamlets the proportion of residents with a LTLI varied from 18.4% in Park, to 11.1% in Millwall. The age distribution within wards will be a contributory factor (London Borough of Tower Hamlets, 1994) However, LRC analyses of census data show a clear association between deprivation at the ward level and LTLI. Within the most deprived fifth of London wards (as measured by the Index of Local Conditions), long term illness was some 23% greater than expected (LRC, 1996). The evidence confirms the strong association between deprivation and ill health at the local level. A high proportion of wards in the four boroughs fall into London's most deprived fifth of wards (Cattell, 1997).[9] Chances of experiencing poor mental health are also greater in highly deprived wards. In Tower Hamlets, Spitalfields ward - one of the most deprived wards in the country - has a rate of admission to acute psychiatric beds which is almost double that of the average rate for the borough as a whole, (Kings Fund, 1995).

Data on hospital admissions confirm evidence for mortality and LTLI.[10] Data for 1993/94 indicate that the highest standardised admission rates in London (based on the values for London as a whole) were found in Tower Hamlets (123.2) and Newham (120.8). The rate for Hackney was 104.0, and for Waltham Forest 106.1 (LRC, 1996). At the ward level, the most deprived fifth of London wards (a high proportion of which are located in the four boroughs) had age and sex adjusted admission rates which were over 20% higher than expected, if London rates were to apply (LRC, 1996). [11]

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9 See Appendix 5

10 Data sources such as hospital admissions carry a health warning from Health Authorities who do not consider them to be reliable. The LRC point out that high rates of hospital admissions may suggest higher levels of illness amongst the population, but could be indicative of differences in the local availability of hospital beds, or admitting policies (LRC,1996).

11 For specific conditions, Newham (156.7) and Waltham Forest (156.1) had the highest admission rates in London for CHD the year 1993/94 while high scoring London boroughs for respiratory diseases included Newham and Tower Hamlets. Cancer admissions were higher than the London average in Hackney, Tower Hamlets, and Waltham Forest (where they were especially high) and lower than the London average in Newham. Mental health admissions were higher than the

Especially high rates of conditions generally associated with poverty and deprivation are evident in both Health Authorities. Respiratory disease for example, including asthma and TB, is a cause for concern. Admission rates for asthma in East London and the City for persons aged 16-24 were at least 80% above national rates, and almost the highest in the country.[12] The incidence of TB is high in both Authorities. Survival rates for breast cancer are poor in East London and in Redbridge and Waltham Forest. While there was a 5 year survival rate of 80% for women aged 15-74 with breast cancer in mid Surrey over the period 1986-88, the survival rate in Redbridge and Waltham Forest was 65%, and in East London 60%. One reason is thought to be the link between material deprivation and lower survival rates (R&WF HA, 1995).

Certain behaviours are also likely to play their part in the poor health record of residents, but, as it was suggested earlier, they are difficult to disentangle from factors connected with deprivation. Elcha is one of a growing number of districts where lung cancer is the most common cause of death in women. Local mortality rates are 41% and 31% above the national average for men and women respectively (Elcha, 1995). Smoking in Waltham Forest has been associated with about 165 deaths each year in Chingford; 140 in Leyton; and 134 in Walthamstow (R&WF HA, 95) The higher rates in Chingford - the least deprived part of the borough - is the reverse of what would be expected.

Age

Deprivation may be having more of an effect on the health of younger sections of the population than on older. Unexpectedly, SMRs amongst younger age groups appear to be especially poor in London. Although some of the highest SMRs have been found in the Northern industrial towns and coal mining areas (Willmott, 1994), when the under 65s are considered separately, London boroughs are amongst those with the highest SMRs in the country. (Drever and Whitehead, 1995) Under 75 and under 65 SMRs are particularly high for the three East London boroughs (LRC,

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London average in all four boroughs, but markedly high in Tower Hamlets (152.6) and Hackney (198.6) (LRC, 1996). North East Thames Regional data indicates high rates of admission for diabetes and its complications in Waltham Forest and Hackney (R &WF HA, 1995)

12 Reported rates were highest in Tower Hamlets. Admission rates for those over 65 were 100% above national rates, and for children (0-15) 80% above national rates (Elcha, 1995 (b)). The Newham 8 year olds study showed that in 1993 17% of all 8 year olds reported ever having had asthma or attacks of wheezing in the chest. Boys and white children were particularly vulnerable (Griffiths, 1994). Action to control TB has been selected by North East Thames region as an additional Health of the Nation priority area.

1996). The differences in rates amongst young and middle aged men are particularly marked (LRC, 1996). Local Health Authority examination of mortality from all causes shows a striking effect of age in East London. Death rates in the Elcha district for children and younger adults are considerably higher than national rates. For males and females combined the SMR in children (aged 0-14) was 114 for the 1988 to 1992 period and the SMR in younger adults (aged 15 to 64) was 133. In older adults (aged 65 to 74) mortality was still high - SMR 119. But for elderly people (aged 75 and over) mortality rates locally (SMR 96) were significantly *below* national rates (Elcha, 1995).

Elcha suggest that two explanations are likely to contribute to this paradox. The first is that elderly people tend to leave the district when they become ill - the number of people moving into nursing and residential homes in the district is about half the national average. The second explanation they suggest is that there are "two populations" - a younger population that is particularly socio-economically deprived with a high incidence of illness, and an older population that is relatively healthier. Evidence from census data on the prevalence of limiting long term illness according to age supports this interpretation and confirm the mortality data (Elcha, 1995). High rates of illness are evident in younger adults (a ratio of 134 for men and 144 for women under age 65) in the Elcha area but lower rates for elderly people (108 and 104 for ages 75 and over). The ratio for both men and women under 65 in Tower Hamlets is particularly high at 138 for women, and 139 for men (Elcha, 1995,b). The percentage of Newham residents with long term illness in the age range 30-pension age is more than 40% higher than the London rate (Griffiths, 1994).

For Elcha, it is the relative youth of the ethnic minority communities which explains the difference in the health experience of the two populations. Arguably however, very high rates of unemployment amongst all those of working age, and particularly amongst 16-24 year olds evidenced in local boroughs, are likely to be having an effect across all population groups, though some ethnic minorities are especially badly hit. Some studies, as we saw earlier, have indicated that the unemployed and poor suffer from forms of social as well as material deprivation, while other studies suggest that social deprivation is more crucial for the health of the young. The combined effects of material and social deprivation could be taking a toll on those of working age. Unemployment and social deprivation, as we saw earlier, are closely linked to poor psychological a well as physical health.[13] There are high proportions of many of the recognised vulnerable

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13 A recent national survey found that women, people who live alone, people living in rented accommodation, urban dwellers and the unemployed were most likely to have had some kind of neurotic health problem. Separated men, lone parents, people living alone or without close

categories of people living in the four boroughs, including the unemployed and economically inactive, people living in rented accommodation, and lone parents. Admission rates for psychological disorders are high in all four boroughs.[14] There is also evidence that the ratio of people with severe mental illness (ie schizophrenia and paranoid psychosis) to those with less severe problems (depressive disorder and anxiety states) is higher in East London compared with the country as a whole (Elcha, 1995). GPs surveyed by the R&WF FHSA identified depression, neurosis, psychosomatic and other psychiatric symptoms as a major cause of work in primary care, creating heavy pressure on GPs individual workload, (R&WF FHSA, 1994). Some black groups are over-represented in the statistics. Bangladeshi adolescents for example, are presenting in greater than expected numbers to mental health services with severe mental illness (Elcha, 1995). The stress associated with deprivation will be taking its toll; certain groups, including unemployed Bangladeshi youth, may be facing additional problems associated with a traditional culture under attack.[15]

Unemployment cannot directly explain the poor health of children in the area, but the very high proportion of children living in low income and unemployed household in the four boroughs can.[16] A local survey based on a sample of 593 children showed a clear link between material deprivation

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relatives were the most likely to have symptoms, and people living in couples with no children the least likely. For psychiatric disorders, two factors were strongly related - employment status and age. Unemployed and economically inactive people were more than twice as likely to have most disorders compared to those working full time. Alcohol and drug dependence is associated with younger age groups, (OPCS, 1995(b))

14 In East London and the City the rates of admission to hospital for psychiatric disorders are relatively high. Admission rates for residents aged 15-64 in 1991-92 were 5.3/1000 in City and Hackney, 4.9/1000 in Tower Hamlets and 3.6/1000 in Newham. (Elcha, 1995 (b)) In 1989 Waltham Forest had a standardised admission rate of 116.2 for those aged 16-64 compared with the standard rate of 100 (R&WF HA, 1995)

15 A small-scale study in Newham has helped to illustrate the link between an individual's poverty and their physical and psychological ill health. A relatively high proportion of a sample of benefit recipients said that they had shown signs of stress since being on benefit. The most common symptoms reported were feeling depressed (76.3%); loss of temper (68.4%) and loss of sleep (68.4%) 21% said they were taking tranquillisers since living on benefits, 17% said they were taking other drugs. 70.7% of respondents felt that their physical health worsened since being on benefit. The more common conditions they complained of included: asthma; weight loss; gout; stomach complaints; arthritis; and lower resistance to colds and infections. The authors found no evidence to show that people were smoking and drinking more than previously. In fact many people said they had cut down." (Aston Community Involvement Unit,n.d) .

16 See Cattell, 1997

and being admitted to hospital care in East London. In 50% of the cases neither parent was employed, 59% of the families were living in overcrowded and 30% in seriously overcrowded conditions. 28% had an inadequate water supply or sanitation, 24% reported significant damp (London Borough of Tower Hamlets, n.d).

Children not only suffer from material deprivation. An indication of deflated hopes and aspirations of children (which may well impact on health in some way) was indicated by one survey in which only 28% of a sample of children in Bethnal Green thought that they would be able to have a worthwhile career when they left school, (Elcha, 1995,b). A disproportionately high level of teenage pregnancies in Waltham Forest (Mori, 1995) may reflect a lack of opportunities for young people in the borough. A Mori study for Waltham Forest indicated that family concerns were the biggest perceived threats to mental health - more specifically serious illness in the family (52%) or parental separation (28%). Bullying, in particular racially motivated bullying, is a common concern (around 1 in 5), with Asian children most concerned. (Mori, 1995).

Very high levels of poverty and deprivation are reflected in very high local rates of perinatal and infant mortality. [17] In 1992 Waltham Forest and Newham were among boroughs with the highest perinatal mortality rates - over 10 per thousand births. Infant mortality rates are also high, (R&WF HA, 1995). Low birth weight, congenital abnormalities, maternal age (very young or older mothers), social class and ethnic background are amongst the factors associated with infant mortality and highlighted by the health authority. Willmott suggests infant mortality is a measure of the health of babies and the conditions under which they live, and perinatal mortality rates are largely an indicator of the health of mothers and the conditions under which they live, (Willmott, 1994). Both mothers and babies appear to be suffering especially from the harsh effects of deprivation in Newham and Waltham Forest. To assess reasons for this, research would need to be conducted which could identify the role of certain deprivation factors, demographic factors, or local conditions.

Socio-economic characteristics and place

The 1991 Census put a question on ethnicity for the first time. Both Health Authorities see the ethnic diversity of the areas as the major influence on the health and disease patterns of the local population. Health Authority reports highlight specific health issues relating to ethnic origin in the

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17 The perinatal mortality rate refers to the number of stillbirths and deaths of babies under 1 week per thousand total live and still births. Infant mortality refers to deaths between 1 week and 12 months (LRC, 1995).

country as a whole. It is difficult to disentangle the health effects of factors not specific to ethnicity however, particularly poverty and deprivation, and factors associated with ethnic group, such as immigration or culture, or medical practices.[18] Deprivation factors are not, of course, ethnic specific. Migration and separation from family members is however, and suggests a need for initiatives aimed at developing support and other networks for people in these circumstances.

Sometimes ethnic factors are highlighted and evidence on class neglected. A study by Balarajan and Raleigh (1990) on variations in stillbirths and first year deaths in England and Wales according to mother's country of birth was used by one Health Authority to illustrate the importance of ethnicity. The study discovered that, for the period 1982-85, there were high perinatal and infant mortality rates for mothers born in Pakistan (18.8 per thousand total births compared with 10.1 for UK born mothers). Their figures suggest however that an important factor was the social class (by occupation) of the father. If we compare families where the mother was born in India, the UK or Pakistan, for the UK and Indian families the extra risk in lower socio-economic households is apparent, but was much less marked than among Pakistani families where the infant mortality rate in social class V families is 20.4 per 1000 total births. Babies of Pakistan born mothers and UK born mothers in social class I had a similar infant mortality rate.[19] In another example, a survey's findings based on Newham, (London Borough of Newham, 1992) although indicating that differences in reported incidence of many specific conditions tended to be greater between classes than between ethnic groups, nevertheless gave greater prominence to (narrower) ethnic differences in health experience rather than differences between social classes.

On almost all the measures utilised here, health in the four boroughs - on a range of physical and psychological conditions - is very poor. Certain health indicators are especially poor in the most

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18 The apparent association between stress related disorders and people not born in this country is interesting. Fenton argues that there are operational problems in using the term 'ethnicity'. It does not describe a discrete segment of the population, and the term does not represent a single complex of shared experience, it is not a unitary concept. (Fenton, 1997). His research demonstrates that different aspects of ethnicity can have health effects, but he argues that the effects of specific aspects, that is migration or culture, need to be examined. The depression experienced by South Asian women in Bristol for example was found to be frequently connected with migration, particularly with separation from family members. His research with women in an inner city district suggests that the poor self reported health of Pakistani women was linked to living in high rise apartments, isolation, worry about surviving on a low income, a shift-working husband, lacking social support and confidantes. (Fenton,1997).

19 Pakistani mothers: Social class I (7.3), class II (13.1), III non man. (18.4) III man (15.8), IV (16.8) V (20.4)

deprived wards where there is evidence that they are worsening. Although the health measures examined here are very broad brush., the data do re-inforce the established links between class, poverty, deprivation and health at the local level. Health authority data by concentrating overwhelmingly on variation by ethnicity, may at times be in danger of neglecting underlying causes. Class continues to be important as the focus for analysis, because, as it was suggested earlier, the concept encompasses a wide range of inequalities. Differentials based on the Registrar General's scale however, it was suggested earlier, may be understating them at the local level.

An additional factor associated with social class is that it largely determines place of residence. Literature reviewed in Chapter 3 suggested that features associated with the area itself, and not simply the poverty experienced by the people living there, can have an additional effect on health. The data examined above are unable to indicate whether there are additional factors at play. This will be explored in local case studies.

Three factors emerge however in relation to the question of London's anomalous health position. Firstly, this part of London has apparently 'caught up' in health terms with other parts of the country whose experience of poverty and unemployment has been of longer duration. We could expect to see a worsening health profile in the four boroughs during the 1990s unless additional resources are put into health and other services. Secondly, evidence indicates that there are 'two Londons' in terms of health and deprivation, and that aggregating health data on London as a whole is not helpful and obscures wide variations between areas. Thirdly, compelling evidence for the four boroughs suggests two populations in terms of age and health experience. A North/ South health divide may well be less evident if data is restricted to the under 65s.

The rest of this chapter will now examine the role of local health policies in the structure of health and illness in the four boroughs.

Responses to poor health

The Health authorities have responded to relatively high levels of poor health by aiming to reduce inequities between groups - including those of age, gender and ethnic background - and areas within health authority districts. Programmes are planned or in place to research needs, to develop community services, and encourage health promotion projects. To achieve improvements in services, they are entering into alliances and partnerships with others, and encouraging participation. The emphasis is on targeting those seen as most at risk. Health promotion for example is a key strategy for both Authorities. Action includes exercise programmes, health promotion clinics, and

action on smoking. The latter includes a 'Ramadan stop smoking project' for example instigated by the voluntary sector in Tower Hamlets. Such projects illustrate the Health Authorities' preference for highlighting ethnicity as a cause of ill health, or, in this case, health related behaviour. It was noted in Chapter 4 however, that giving up smoking is especially difficult for people who are experiencing the low self esteem and powerlessness associated with being poor.[20]

We saw earlier how the most deprived wards in the area tend to have the worst health. Both Elcha and Redbridge and Waltham Forest highlight geographic inequalities between localities in the areas bounded by the health authorities. In Redbridge and Waltham Forest, for example, health authority policy is to identify factors which contribute to wide variation in mortality across electoral wards and investigate whether these inequalities may be lessened through health service activity (R&WF HA, 1995). It is unlikely however that improvements to health services alone could make substantial roads into tackling spatial inequalities, though they will certainly help.

Needs assessment research is being undertaken locally to ascertain the needs of poor groups of people and those who live in poor areas. Examples in R and WF include research into needs of the homeless; needs and service provision in a HAT area; The FHSA Newchurch Care Demand project; a small area survey (R&WF HA, 1995), and a project on the health needs of Asian and Afro Caribbean elders (R&WF FHSA, 1994).[21] Needs research indicates that services do not match need. In Waltham Forest for example, although a higher level of service provision was usually achieved in the South (and neediest) and Central parts of the borough, this did not reflect the

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20 Both Health Authorities are responding to the *Health of the Nation*, the Government's health strategy for England launched in July 1992. The Government's overall goal was to increase life expectancy, increase lives lived free from ill-health, reducing the adverse effectsof illness and disability by promoting healthy lifestyles, physical and social environments and, overall, improving quality of life (HON.1992, p.13) It selected 5 key areas for action - Chronic Heart Disease (CHD) and stroke (including their known causes: smoking, diet, alcohol); cancers; mental health; accidents; HIV/Aids, drugs and sexual health. TB has been included as a sixth priority in East London.

21 Newchurch and Company analysed primary health care needs and services by locality for Redbridge and Waltham Forest FHSA. A Care Demand Index (CDI) was developed to assess the potential needs across the area according to priorities agreed amongst health care professionals working within the area (Newchurch, 1994) Areas of greatest need were also found to be those of greatest concentration of population. The indicators were: limiting long term illness; over 85s living alone; overcrowded households; permanently sick or disabled aged 50-64; two or more people aged 75+; lone parents aged under 25; under 5s; long term unemployed; ethnic minority born overseas; households without amenities. Needs were then compared with existing services- district nurses, health visitors and GP list sizes in each locality.

severity of potential needs . Standards of GP premises were poor for example, and the provision of district nurses inadequate (Newchurch, 1994). Cathall ward, in which one of the case studies is situated, did particularly badly (Newchurch, 1994). Reports like this are important in the light of suggestions that better health standards in London as a whole may be related to better provision of health services.

Primary and Community Health Services

Waltham Forest as well as the Elcha districts fall into a London Initiative Zone which means that special funding is available for a limited period to enable new community and primary care services to be developed.[22] Interestingly, there seems to be a resurgence of ideas which lay behind the establishment of the Peckham Health Centre of the 1920s and 1930s (Lewis and Brooks, 1983). Health authorities are appearing to go some way towards adopting a social model of health, by not divorcing health and health services from aspects of community life. A planned multipurpose primary health and social care centre in the Royal Docks area is to provide not only primary and community health care, but also a Citizens Advice Bureau, adult social care and a nursery (Collaborative 1995/96). *If* this project comes to fruition - and Elcha is operating under a climate of *cuts*[23] - then this kind of community facility could do much to improve the health of those using it . This would happen not only in a direct sense of encouraging take up of health services but also by providing a range of facilities, by developing social networks and increasing access to information and other resources. A similar facility is planned for the South Canning Town area of Newham, part funded by the Single Regeneration Budget (South Canning Town and Custom House Community Renewal Project, 1996). The latter project - St Luke's - located on Keir Hardie, one of my case study estates - is now underway. Anecdotal evidence indicates problems connected with the Health Authority's share of funding and equipment. Regrettably, when Health Authority budgets are tight, there may be a tendency for some of the monies earmarked for new projects to sometimes be siphoned off into regular service budgets.

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22 Priorities for the year 1995/96 in Redbridge and Waltham Forest included a development programme to improve primary and community services (39% of GPs are single handed), and an increase in the numbers of practice nurses, receptionists and practice managers. Projects include an ethnic monitoring health project; and a family planning project aimed at young people. GP premises have been upgraded and improved, and new units are planned (W18 - R&WF FHSA 1993/94; R&WF HA, 1993/94) LIZ funded projects for primary care and community health services in the Elcha district include development of community health services in general practice; supporting small practices; and new health centres and primary care centres.

23 Estimates suggest a shortfall of some 14 million pounds for the last financial year.

Additional schemes, which, though ostensibly appearing to have an educative role, can also be seen to have a potential role in ameliorating social deprivation, fostering the integration of the individual into the community, boosting social networks, and thereby improving health. A "community mothers scheme" for example, is planned for East London to provide extra support to socially disadvantaged first time mothers through the use of experienced volunteer "community mothers". A Newpin centre in Newham is now underway and provides support to women in coping with their children. The project uses a combination of self help, support group work, therapy and training and is undertaken in co-operation with Health and Social Services departments (Collaborative 1995/96). Women attending Newpin - which is located on the Keir Hardie estate - were interviewed during field work for this thesis. The underlying philosophy of Newpin is that women in disadvantaged circumstances can be helped to take control of their lives. The implications for health are clear.

It was suggested in earlier chapters that participation, including participation in health and health related projects, would be of benefit to the health of individuals. Both Health Authorities want to work with local people and to increase the involvement in decisions about the future of health care. Publications, public meetings, open days, and focus groups have been used to inform, assess views and encourage involvement. In addition, there are some innovative community development projects. One, a community health project, is a joint project with the Waltham Forest Housing Action Trust (WFHAT) on two estates in Leyton - Oliver Close and Boundary Road. A worker on the Oliver Close project reports that the project has had great difficulty in getting people involved in health related initiatives. Getting the more isolated involved, or even accessing them, has been a particular problem. Very few people turned up for a no smoking course for example. "We haven't cracked it yet. Sometimes it feels as if you are banging your head against a brick wall. We hope to do more social activities to bring people in. But even then, you tend to get the more active people turning up" (project worker). There seems to be an element of mistrust on the part of residents. Having felt neglected, they ask "why have you waited so long?". A problem with Oliver Close estate, as I discovered later, is that, unlike nearby Cathall (one of the case study estates), there is no sustained history of community development work and voluntary activity on the estate. People cannot be expected to participate overnight.

Policy Responses to Poverty and Deprivation

Health Authority policies are not, of course, the only policies which will impact on health. Policy responses to poverty and deprivation are also highly relevant. A number have been examined in

relation to the four boroughs which are likely to impact on poverty, community life, and by extension, health. They can be broadly grouped into those which focus on places, and aim to regenerate a deprived area, and those which focus on people, and aim for example to alleviate the poverty of vulnerable groups, or to involve people in the local community. Examples of urban policies; anti poverty and community development work; housing initiatives; and environmental initiatives are described and reviewed in the appendix. The examples suggest a number of conclusions. Firstly, large scale economic re-generation does not always benefit local residents. Secondly, voluntary sector and community development work, as well as local authority anti-poverty strategies, although certainly working in the right direction, are nevertheless severely hampered by lack of funds. Thirdly, targeted housing regeneration programmes benefit tenants, as does sustained work and support to tenants by organisations such as Priority Estates Project. There still remain many estates in East London, however, which are starved of resources and opportunities for involvement.

To provide services capable of tackling deprivation and health effectively may require a strategic approach on the part of central and local government, backed up by adequate resources. Health authorities know what is needed to tackle ill health associated with material and social deprivation, (even if the emphasis on health promotion or vulnerable groups is sometimes a little off target) but more resources are needed so that services are improved in the most deprived areas and so that new projects do not fail for lack of funding.

This chapter, by examining available statistics on health, has not been able to utilise a social model of health. Some of the policy responses, by focusing on community initiatives, appeared to have worked within a framework which includes a social model however. The social networks aspect of a social model of health will be explored in the case study chapters. They will also investigate what this chapter has not been able to - the extent to which very localised conditions, including services, facilities and so on, impact on poverty, social networks, and health.

7.THE KEIR HARDIE ESTATE

One of the key themes addressed in this thesis is the extent to which place makes a difference to socio-economically determined health inequalities. This chapter moves away from the larger structural approach adopted in the last chapter, to focus on the micro-level, the neighbourhood, and looks at both structure and action. It also moves from a disease based model of health to encompass features of a social model, to include aspects of facilities, social networks, and *quality of life*.

A second key theme concerns the mediating role of social networks in health inequalities. Community factors are examined in the light of their actual and potential implications for social networks. Key issues here concern features of the local community which can act to 'include' people into their community and which can exclude Can we identify characteristics of local communities which foster health promoting networks? What role do opportunities for participation in formal and informal organisations play?

The two estates selected as case studies were chosen because a) they have similar profiles in terms of poverty and deprivation, and b) they appeared to have some different 'community' characteristics. In particular, Keir Hardie appeared to have few opportunities available for participation in organisitations and activities, while Cathall , with a history of sustained community development work, had many. It transpired during fieldwork however that opportunities for participation was not the sole, or even main feature which contributed towards a strong sense of community and fostered social networks on the two estates. Participation was however, as the next chapter will show, one of the key influences on the pattern and components of an individual's networks and had important implications for health.

One of the issues looked at in the chapter following this one concerns ways in which residents' social networks can help them cope with poverty and deprivation and protect their health. However, patterns of social networks, the social organisation of an area, are, in themselves, this present chapter demonstrates, in part determined by structural factors. These include work, clubs, facilities and housing, and opportunities for formal and informal participation. Communities are not created (or destroyed) overnight: the history of an area is also influential in the creation of opportunities for health promoting networks. Patterns of social networks are also influenced by subjective factors, by perceptions of community, its reputation, a sense of attachment. These are to some extent influenced by structural factors themselves.

The first part of this chapter provides a brief community profile of the area. It looks at facilities and services, housing, employment, the reputation of the area as well as its demographics, levels of poverty and unemployment, and subjective accounts of health standards in the area. The second part goes on to explore more fully residents' accounts of community life, both past and present, and the implications they have for social networks and health. Apart from some added statistics on demographics, employment and poverty, this chapter is based entirely on interviews with residents and professionals working on the estate. In the first part, people are reporting on the area. In the second- on aspects of community- people are largely reporting on their own experiences and attitudes towards the estate as a community.

A PROFILE OF THE KEIR HARDIE ESTATE

Until the mid-1970s, when containerisation precipitated decline, this had been a dockside community. Described as a whole way of life by people living and working there, the docks and the dockside factories south of Canning Town were the backbone of the area. [1] Economic decline has had an impact on a par with the blitz, and the post-war slum clearance programmes. According to a local priest, all three have had some effect on population movement. Most of the area was flattened during the blitz, only St. Luke's Church (the Cathedral of the East End) and a few pubs remained. The estate was built after the war, and added to in later decades.

The Keir Hardie Estate is a generic term covering several small scale council developments in the South Canning town and Custom House area of Newham. There is no commonly agreed view as to where the estate itself begins and ends: to some it is simply the historic post war core south of the recreation ground, to others it is the collection of council developments comprising Redbrick, St. Luke's and Radland/Hooper. Though a relatively small area, Keir Hardie is made up of parts of three wards: Ordnance, Beckton and Custom House and Silvertown. Bounded by major roads -

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[1]The closure of the Royal Docks was calamitous for Newham, but job loss was not restricted to ship repair, trade, and their satellite industries. Between 1981 and 1991, losses occurred virtually across the board: the industrial sectors of chemicals, food and drinks, printing, timber, engineering and transport were particularly badly hit. Although not inconsiderable growth occurred in public administration and financial services, it was not enough to compensate for the decline of industrial sectors, and the recession of the early 1990s did not, in any case, leave growth areas unscathed. (Cattell,1997). Investment drawn to the wider area has gone mainly to the adjacent sites of Docklands and Stratford. Jobs in Canning Town wards have been declining dramatically. Local people have not benefited from the new employment brought to the wider area. Although the number of jobs in the LDDC area increased by 28,000 between 1981 and 1994, in the wards in the Canning Town SRB bid area male unemployment rose from 13.3% to 18.7%.(Canning town SRB bid, 1995).

the A13 to the North, Silvertown Way to the West , railways and the docks to the South, the area is relatively isolated. The estate itself is not a walking or a shopping area, you need a specific reason to come on to it. Conversely, the geography of the area has reportedly helped to foster parochial attitudes amongst residents: the A 13 (dubbed the 'Berlin Wall' by residents) creates psychological as well as physical barriers.

Professionals' comments suggest that it is an excluded area, not only in the physical sense, but also in the sense that there are very few facilities - no bank, no Social Security office, no secondary school, few shops, nothing going on, and few leisure facilities. Local shops on the estate have declined dramatically in the last few years, and the last remaining bank in the wider area of Canning Town - the Nat West - followed its competitors and withdrew its operations from the area after it had been held up five times in six months. A chip shop and corner shop remain in the shopping parade. However, there are shops to the east in Freemasons Road, on the fringes of the estate, and there is the well used Rathbone market to the North West. The market lies outside the area, but is relatively close and a traditional shopping and meeting place for local residents .

Opportunities for social interaction, though still very much evident, are not as plentiful as they were. Residents contrast today's leisure facilities with those available when they were young. At one time, for example, there152 were regular dances, and the Canning Town area had three cinemas. Now there are none . There are some churches on the estate - including the Methodist Keir Hardie Community Church, but attendance does not appear to be high. St. Luke's building, the old 'Cathedral of the East End', has now become a focus for a regeneration project. In the wider area of Canning Town, however, St. Margaret's Catholic Church on the Barking Road attracts hundreds to Sunday Mass. The priest is a local boy, the first in his family not to go into the docks for work. This is significant, and in part explains his success in drawing them in. Canning Towners tend not to trust outsiders, but they will use facilities provided by locals. People can drop into the Tarling Tenants Association shop for information and a chat for example. Volunteers work extremely hard to provide help and advice to local residents, but sometimes feel that they are 'picking up the pieces for the shambles of community care'. In addition, thriving pensioners' clubs exist, run by pensioners themselves. Additional facilities include The Mayflower, one of the old Christian settlements which traditionally have been a feature of Canning Town for many decades. It is located on the estate, but does not appear to have the same input

from residents as it once did.[2] One of the professionals suspected that it might be too strict for some.

Services, like facilities, have been neglected. There is a housing office located on the estate, but few other services, and no public library. There are two doctors surgeries however: both are single handed practices, and GP turnover is high. A branch of Newpin is based at the Mayflower Centre. This is an excellent and apparently effective service which works with mothers in Newham suffering from depression, feelings of isolation, childcare and relationship problems. Women I interviewed attending Newpin, as we will see later, spoke highly of its effects in broadening their supportive social networks. There are three primary school on or near the estate, but, surprisingly for the size of the area, no secondary school. Older children must cross the 'Berlin Wall' to reach one. Levels of attainment in Key Stage two in local primary schools are very poor.[3] Some of the parents are concerned about the poor educational standards of their children, and see lack of resources as the major problem. The Church of England school has excellent school governors who, though some are illiterate themselves, see education as the key to improving their children's chances. Many others however, reportedly do not give priority to their children's education. In an area where traditionally, unskilled work was plentiful, education could be considered unnecessary. Poor educational attainment has been linked to poor health.[4]

Opportunities for children to lead healthy lives, in terms of beneficial exercise but also in the social life which contributes to a general sense of well being, seem few. Residents as a whole are united in their anger at the lack of facilities for the young. "There's nothing for children. There's plenty of Betting shops, but nothing for children." (Diane 36) . "Because of cuts there are

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[2]The Mayflower provides various community outreach facilities, including a loner club [sic] for the elderly with a home pick-up service, as well as a coffee bar and launderette, healing and sanctuary project, youth group, and pensioner's club. These facilities now appear to be targeted towards people with special needs. The Keir Hardie Neighbourhood Church offers a range of activities for the local community, including playgroups, holiday play schemes, and a senior citizens group. Located outside the area on the Barking Road, Newham Community Links is a charity part- funded by Newham Local Authority. It provides a variety of services but does not appear to be well used by Keir Hardie residents.

[3] In Hallsville School, for example, only 20% of pupils achieved level 4 or above in 1996, 15% in maths, and 15% in Science. These results are considerably worse than the Newham average and when compared to proportions for England as a whole (56%, 53% and 61% respectively) indicate that local children are considerably under-achieving.

[4]See for example Benzeval, M. Judge,K. and Whitehead,M 1995; Brynner, J. and Parsons, H, 1997.

few play schemes, no after school clubs and no park keepers. The Youth House is there, but you still have to pay money to go on the trips, anyway, they let you down, and its not open everyday", (Rose). "The Leisure Centre is too pricey for kids, and the park is a park for dogs", (Michele 34). People are often fearful for the safety of their children, perhaps especially so at this time following the young Beckton boy's murder [Daniel Handley] last year and because a local child had recently disappeared. Their fears are compounded by the cuts which have reduced park keepers to a system of roving parkies. Children now have very little access to play areas - previous derelict sites have been built on, there are only one or two open 'parks' - recreation grounds with inadequate facilities. Professionals confirmed residents' comments, and reported that there was a desperate need for provision for children and that existing services were oversubscribed and totally inadequate for needs.

There is little provision for young people. The district was well provided with youth clubs in the past, but now, most youth work, rather than being preventative, is for youngsters with problems. As one resident commented: 'The old youth clubs have been closed. The council is making more cuts in leisure than in anything else.' Consequently, groups of 'twenty or thirty of them [youngsters] hanging around making a nuisance of themselves in the streets in the evening' is commonplace (Jackie). Residents do not hesitate to identify more serious consequences: "The kids get into mischief because there nothing for them to do. They break into the doctors to get at the drugs. When I was a kid we didn't know what drugs were", (Jennifer). 'The kids turn to drink, crime and drugs. That's what Newham is all about now." "They were dealing right above the police shop on the estate. And the police didn't even know", (Yvonne).

One resident is clear about what should be done. 'Give kids some responsibility and a place to do things in with people of their own age, then they wouldn't hang about the streets. Most kids are good given encouragement and help.' However, she is also critical of parents' lack of control: "I've seen kids smashing up cars at 4 O'clock in the morning, the parents are too drunk to be bothered I expect". Another helps out in a local school. She is critical of parents who 'don't provide good role models for their kids, the ones who cant even be bothered to read them a story.' (Rose). Comments like this appear to suggest that there is evidence for a break down in cultural values amongst present day parents, but the evidence is patchy and education, in any case, has never been seen as a priority locally.

All the professional respondents confirm this part of Newham as highly stigmatised: "Every borough has to have an area or an estate with a bad reputation. Here its Canning Town and the

Keir Hardie estate". (Housing officer). Its public perception as a hard, rough area goes back decades, and probably even longer. Even Dickens was aware of it (Priest). It is generally recognised that a number of criminals - including armed robbers and their families - are settled in the area. There is a fairly high incidence of crime on the estate and the surrounding area - in particular car theft, burglary and street crime. However, police comments suggest that it is no worse than elsewhere in Newham.[5] Residents, as I show later, do not accept the public perception of the area as rough and stigmatised. One spoke angrily about what she identified as the causes of crime, and about inappropriate methods of punishment. "They go in for drugs-running because there aren't any jobs, there's no end to it...Then there are some youngsters may have a mum who's an alcoholic, so the kids are seen as losers. Then they sling young offenders in the Young Offenders unit, where they bugger them!"

Before the war some of the worst slum housing in London was found in South Canning Town and Custom House. Today there is a mix of housing styles and ages - solid post war and later terraces, low rise maisonettes and flats, and less popular towers. The latter - located in the less pleasant part bordering on the A13 - replaced the notorious Ronan Point and similar blocks. It was here in 1968 that unsafe pre-fabricated building methods resulted in the skyscraper collapsing dramatically like a pack of cards. Unlike some other parts of East London, this area is not going though a process of gentrification. There are no large Edwardian and Victorian houses in South Canning Town, and the small terraces which characterised the place before the war did not survive the attentions of the Luftwaffe. Despite the impact of 'The Right to Buy' on areas of (largely terraced) housing on the estate, most of the housing remains council owned and is unlikely to go upmarket. 70.5% of homes in the South Canning Town and Custom House area are socially rented, a much higher proportion than the average for Newham as a whole (30.8%). 25.4% of homes are owner occupied in South Canning Town and Custom House, compared to nearly 50% for Newham as a whole. Canning Town and Custom House is thought likely to remain as it is - an inner city area made up of families who have been there for generations, plus a smaller proportion of immigrants and refugees.

Newham's high and growing proportion of children is reflected locally.[6] Under 18s for

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[5] E16 - of which the study area forms a part- is reportedly the highest insurance premium rated area, and some companies won't insure houses or cars in the Canning Town and Custom House area.

[6]The size of the population to which these statistics refer is 15,601, and covers the whole of the South Canning Town and Custom House area. Interviews focused on a smaller sub area

example, make up 29.7% of the population of South Canning Town and Custom House, compared to 27.8% in Newham and 21.7% in London as a whole. The population of the estate itself is further characterised by a high proportion of pensioner *households*, a relatively smaller proportion of earning families around the 40 years age mark, and then a high proportion of young people.[7] Dubbed 'pram city' by a newly arrived social worker, single parents are a highly dominant feature of Keir Hardie estate. Beckton Ward is said to have the highest proportion of single parents in the country. Silvertown Motel, just outside the area, houses many single parents who are locals. It provides short term accommodation for people waiting to be re-housed. Many of them are prepared to take this depressing option, it seems, because their families are living on Keir Hardie and they wish to remain in the vicinity.

Several of the professionals described a visit to the estate as walking into a time warp, a point reinforced by new residents. For example, the overwhelming majority of the population is white (around 83%), Black people are reluctant to move onto the estate, they fear isolation and racial harassment. Indeed two of the local wards (Ordnance and Beckton) have been targeted by the BNP. Long-established residents, however, include several Black families who settled here after the first world war, and who are now part of the indigenous population. The estate is something of an anomaly for Newham, 42% of the borough's residents belong to a non-white ethnic group.

Residents are more likely to be unskilled than in other parts of Newham. 10.7% of workers are unskilled in the wider Canning Town SRB area, some 70% above the Newham average. Semi-skilled and unskilled social classes are over-represented. There was once plentiful demand for unskilled and semi-skilled manual labour, but this ceased

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of some 6 Enumeration Districts. Statistics for South Canning Town are taken from 'Aston Community Involvement Unit, They Don't Understand Us At All: local views on regeneration in Canning Town, Sept 1996, and for Newham, from Cattell,V., London's Other River: people, employment and poverty in the Lea Valley, Social Policy Research Centre, Middlesex University, 1997.

[7]Well over 40% of all households in one Enumeration District are pensioner households, and nearly 50% in another. Children and young people dominate another Enumeration District, where 15.8% of the population are under five, and 45.8% under 18. The Newham averages are 8.9% and 26.9% respectively. The area is one of low rise blocks with accommodation in maisonettes and flats. In the same Enumeration District, nearly a third of all households are lone-parent households, compared to a Newham average of 7%.

with the closure of the docks and the demise of its satellite industries. The area has never recovered, and new skills have reportedly not been developed (CD officer). [8] Generally, educational attainment is low, illiteracy levels are very high, and reading attainment for children amongst the worst in the country (Community Development Officer).

Canning Town, and the Keir Hardie estate which forms part of it, is a highly deprived area. [9] Ordnance (53.4%) and Beckton wards (51.4%) - parts of which make up the Keir Hardie estate - have the highest proportion of dependent children living in non-earner households in London. (LRC,1996). In 1991 unemployment in Newham, at 19.3%, was the fifth highest in England. 22.1% of men were unemployed and 15.1% of women. Although unemployment in the South Canning Town and Custom House area (20% for men) is slightly less than the Newham rate, on certain parts of the estate, unemployment levels are very high indeed. Male unemployment in one Enumeration District was as high as 30.3% . Many of the younger residents have never had a job.

In South Canning Town and Custom House itself there are very low levels of car access (a rough income proxy). 60.1% of households do not have access to a car, compared to the already high Newham average of 53.5%. On one Enumeration District on the estate, the proportion of poor people on this indicator jumps to 76.1%. A high proportion of residents are on benefits- between 70-80% are on housing benefit, according to a housing officer. A higher proportion of local children are poor enough to be eligible for free school meals than in the borough as a whole.[10] A respondent described the poverty she saw around the Keir Hardie estate: "The single mums you see in the street look harassed, there's a hardness to their faces. Life is so very difficult for them, it is without joy. I've

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[8] In the wider area of the Canning Town SRB area, only 24.8% of 17 year olds remain in education, and only 17% of school leavers obtain 5+ GCSEs at grades A-C. Local wards are all within London's worst 7% of wards for 17 year olds no longer in Education. (Canning Town Partnership, Canning Town SRB bid, 1995).

[9]Churches provide today's equivalent of the soup kitchens . It is not unusual for families to turn up on Friday at the Catholic Church in the Barking Road and ask for food for the weekend. They feed homeless people too, and run a night shelter in Canning Town (not on the estate). Homelessness in Canning town, according to a catholic priest, is as bad as its ever been. Up towards Christmas they accommodate up to 30 people a night. One professional respondent reported that he'd seen single mothers with their babies begging on the streets in Canning Town.

[10]65.1% of Hallsville School children, 57.6% of Keir Hardie, and 51.6% of St Luke's pupils fell into this category, compared to 38.7% for Newham.

seen people in the supermarkets picking things up, looking at their purses, and then putting them down again." [11] Yet another was more hard nosed about poverty, believing that greed and keeping up with the Jones, as well as waste on none essentials like bingo and cigarettes, could acount for why there were high levels of rent areas in the area. (Barbara). Another reseved her sympathy for the 'genuine poor', and was critical of those seen as less deserving: "The young people smoke and drink their rent and get their community charge paid for them. They survive at others people's expense"(Bessie). Again, remarks like these may be evidence of a breakdown in cultural values, but the evidence is insubstantial and inconsistent. Professionals' and residents' opinions on a number of problems - poverty, ill health, education, young people- seem to vary between those who look to culture, and those who look to structure. Professionals tend to be more censorious than residents on the whole. Sympathetic residents reported on how people they knew coped with poverty. For exmple "some of the girls sell the family allowance books to money lenders. Its a regular occurrence" (Val). Differences in attitudes are to some extent, as I will show later, linked to the degree with which residents identify with others.

Given the high levels of poverty and unemployment in the area, we would not expect health standards to be generally good. It has never been a healthy area. Before the war health standards were terrible, but, according to one respondent who knew the area well then, more attention was given by the old doctors in those days. They dedicated their lives to the East End, to the extent that one doctor reputedly had his own sick-bed brought downstairs so that he could continue to see his patients. Now, people are very dissatisfied with the health services they receive. Single-handed practices, lack of appointment systems and long waits in surgery waiting rooms are said to be commonplace, and there are problems in recruiting doctors to the area. The nearby Newham General Hospital is very unpopular. Although some of the scare stories simply aren't true - like going in and coming out with the wrong leg cut off - aspects of the services appear to elicit widespread criticism. Long waiting lists and long delays in A and E are the worst of these.[12] Being exposed to the multi-racial environment of the hospital is also a problem for some Canning Towners- they are simply unused to it, are uncomfortable and have irrational fears about

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[11] Single parents tend to have poorer health than parents living in couples, and the children of lone mothers are more likely to suffer from ill health also. See Popay and Jones, 1989.

[12] East London and City Health Authority are operating under a climate of severe financial cuts.

the treatment they will receive (Vicar). Insular attitudes could have a direct influence on health if distrust of outsiders discourages people from seeking medical attention or taking advice.

Health indicators mentioned by the professionals and residents included a local high incidence of respiratory problems, particularly asthma. As we saw earlier, respiratory diseases- generally recognised as diseases of poverty as well as a consequence of smoking- are growing in the Health Authority district. Respiratory ailments were generally explained locally in terms of high levels of pollution from the A13, the area's location on low-lying marsh land, being downwind of the Tower Hamlets factories, nylon fibres from a bedding factory, damp council properties, building works and the modern predilection for central heating. A care assistant at a local school reported that she'd noted a definite increase in children's asthma since working at the school, and added: "The children need to get out into the fresh air, but the parents can't take them, because they are short of money". Another resident commented "Sometimes you get horrible smells drifting off the docks, from Charrington's and the cooking oil factories maybe. You notice the kids round here coughing more when the smells start up,"(June). A combination of poor air quality and poverty appear to be affecting children's health.

Anecdotal evidence suggests an increase in brain tumours, alzheimers, heart disease and depression amongst adults in recent years. Residents tend to link brain tumours with pollution, especially factory pollution, and the last, depression, with poverty, drug taking, and worries concerning children.

Professionals' explanations for health problems locally tended to focus on either deprivation or culture. Some of the professionals linked the poverty and stress experienced by residents to patterns of ill health, and the loneliness of some pensioners excluded from support groups too. The latter were reported to be suffering from relatively high rates of Alzheimers, a condition reportedly however, not confined to the older age groups. Others were concerned with lifestyle factors, with high levels of smoking, and with junk food consumed by locals, especially the younger locals. One offered a novel theory : a decline in health promoting behaviours could not be divorced from the interests of the multinationals "Young mums round here have not learnt to cook, or to manage on a low budget. They no longer do plain cooking at school. What has happened in education has co-incided with the rise of McDonalds" (Sally). As another put it "There are young women

round here who can't cook a potato. Show them a fresh carrot and they think you're being rude. They're poor but they still go to McDonalds ... The cultural continuity has been broken, the skills are not being handed down" , (Community Development Officer). Food consumption is not the only issue seen by professionals as evidence of a break in culture. One respondent linked consumption patterns with stress related ill health: "They cant afford what they think ordinary people can afford, like highly expensive children's toys ".

COMMUNITY ON KEIR HARDIE

What are the dominant aspects of community life on Keir Hardie? Most of the professional respondents interviewed distinguished between the older generation of residents in South Canning Town and the younger when talking of "community", a term which they strongly identify with the former. The older generation hark back to the pre war period, a golden age, when networks were tight knit, people inter- married and had no reason to lock their front doors. Of course, they were so poor that there was very little to steal. Now, this generation reportedly see their part of East London ruined by rising crime, children out of control, badly behaved youths and people unwilling to clean the common areas.

Yet there are still strong elements of the old East End community spirit and neighbourliness, even if, as both professionals and residents suggest, it is not as strong or as obvious as it used to be. Extended families who have lived here for generations are still very much in evidence; and neighbourliness is a strong feature of some parts of the estate, especially where the housing facilitates it. Community may be, as one or two professionals intimated, generally a restricted, family affair, but if anyone is in trouble, all will gather round to help. A resident described a recent experience which illustrates how the local approach to "looking after your own" can operate. "My life was threatened three months ago by three drunks. One of them came to my house and threatened to blow it up. He said "why have you got all of this?" I didn't contact the police, the locals went after him and dealt with him. A few week later I saw him and he apologised. He'd been warned off" (Barbara).

Community in the South Canning Town of the past: shouting for a cup of tea.

A strong sense of history, born of shared experience and suffering, has contributed to the strong sense of community evident now. Most of the area was flattened during the blitz, only St. Luke's Church (the Cathedral of the East End) and a few pubs remained. Two schools were destroyed, and hundreds of children and their parents waiting for transport

to take them to be evacuated to safer areas were killed when a third school, Hallsville, took a direct hit. A resident explained: "What happened at the tomb school was hushed up at the time, they say there are still 150 bodies which have never been found" (June). The casualty rate in this area during the blitz was very high indeed. Sophie (82) for example, lost a whole family when the school was bombed- her aunt, uncle and two cousins. These memories exert a powerful influence on those who remained in the area, Hallsville is still referred to by some of the residents as 'The tomb school', and St. Luke's church - now the location of a community regeneration initiative - became a powerful symbol of survival. A resident mentioned an additional reason why the threatened closure of St. Luke's galvanised local action, at least amongst those old enough to remember the war. "A big cruise liner, the Rawalpindi, went down on its maiden voyage, torpedoed by the Bismark. Many of the boys on board were from round here, and went to the St. Luke's Youth club. That's why we want to keep it going", (Henry 78). A campaign involving local residents, including a candle-lit vigil, prevented St. Luke's from being demolished by the diocese. A strong sense of local identity and sense of history, have, in this case, encouraged participation in a campaign to retain physical evidence of them.

Residents' accounts of community life in South Canning Town often include comparisons with the neighbourhood as it was. Their stories are tied up with how people coped with poverty and deprivation at the time and how they helped each other. They are important not just for an understanding of community, but for a better understanding in the processes involved in the protective influence of social networks on health. As the next chapter will show, people's accounts of their current lives and health status frequently relate to coping and the role played by others in the process, as well as to incidents in the past.

What was the area like for today's pensioners in the old days? Accounts of community given by older Keir Hardie residents are not myths, the community of the past was rooted in reality, in self help , in youth clubs, but, most importantly, in strong local ties forged by plentiful local work.

A local businessman who, as a child, spent a great deal of time in the area in the 1930s and 1940s, made some unfavourable comparisons with today: "In the 1930s people were brought up to cope, and people looked after each other then. People like 'Pea Soup Jack' who always had a bowl of soup and a piece of bread for anyone who was hungry. There are old people still alive now who owe their lives to him. Now, people don't cope as much

as they used to, there's too much done for them ".

Several of the older residents talked about the mutual aid characteristic of the old days. Audrey remembered her childhood before the war: "Dad was a tally clerk in the docks, and Grandad worked the grain boats. We was very poor, it was struggle to pay the rent, but Mum always found hers. We had three rooms downstairs and another family lived upstairs. When the woman upstairs died my mum looked after the children, she just automatically took over, and did his washing too. Its not like these days, no one helps anyone now. They all helped each other then " (Audrey 73). Another resident also mentioned the self help and mutual exchange we tend to associate with the traditional working class community of the past: "Canning Town was beautiful when I was a child. Dad was a labourer on the roads. When he was out of work neighbours would come in and feed the children" (Ellen 70s). Goods as well as services were freely exchanged: " We always had plenty of rice, because of Dad and Grandad's work, so we always gave neighbours rice, and another man gave us vegetables. Children used to help too, I used to run for messages for an old lady" (Audrey 73) .

Stories of helping each other when times were difficult or resources scarce are interlinked in residents' accounts with memories of more intensive social interaction and tightly knit networks. "You couldn't have had more friendly neighbours round here when I was a child. They exchanged things, they enjoyed each others company. Now people are not so close, they are nice here, but not so close." (Henry 78). "We all mixed in, women used to turn ropes in the street for the children. I miss those days" (Ellen). The three generation household was common. One resident described succinctly how it worked: "The daughters always took the old girls in. You'd find them all sitting in the front windows, watching us play, and shouting for a cup of tea", (Audrey 73).

Several residents mentioned that 'keeping an eye on the children' was a shared activity. The pre war norm of looking out for other peoples children appears to have survived today's changed conditions, at least on parts of the estates. June, a mother of young children, talked about her present neighbours' general helpfulness, as well a the way tragic incidents can draw a community together. "The kids can go out to play in safety. When poor Daniel Handley went missing a woman told me that there was a man sitting in a car near the park where my boys were playing, and not to worry, she was keeping an eye on them I didn't get this sort of help in Walthamstow". Neighbourliness in her block makes June feel more

secure. "Everyone knows one another, it makes you feel safe". It is possible that mutual aid is a reflection in part of the very homogeneity of the place. I will return to this point later.

There were less pleasant aspects of this picture of community life before the war however. Some were excluded from it: "We kids used to go down Victoria Dock Road for winkles for tea. The old Victoria Dock Road was full of lodging houses, the black people lived there. They'd sell bits and pieces. We called them the Johnnies. Our mums would say - if you don't behave, well give you to the Johnnies.".(Ange 73) Racist attitudes amongst some South Canning Towners, as well as distrust of outsiders, seems to have a long history.

Sometimes the memories of deprivation can be swamped by the good memories. The poor housing conditions before the war were mentioned by several though, houses which were small and too close together, and starting off married life in one or two rooms at mother in laws. Some managed to keep their heads above water despite the odds being against them, "Mum couldn't read or write, she could count though, she could count how many bags the coal man brought in, he couldn't rob her " (Amy 90). Shopkeepers catered for their poor customers: "If you wanted bread and jam when I was a child, before the war. you could get a spoon of jam on a plate from a local shop" (Henry 78). Today, the local shop is overpriced, and very small quantities are not on offer.

The question of whether these traditional attitudes of coping and co-operation have survived social change and the welfare state (or indeed its decline) is considered later and in the next chapter. It is clear however that some of the more tangible aspects of local life have changed, and changed for the worse. As well as stories of mutual aid, other dominant aspects of these accounts focused on the leisure facilities and youth clubs available in the area in the past. Residents report that they not only helped to improve peoples quality of life generally, but enabled them to establish friendships which have continued until the present day.

Several, like Ellen, think today's youngsters are less fortunate than they were themselves as children: "Its different now of course. When we were kids we had the Docklands settlement- the Mayflower- we could play netball, do sewing and painting. they don't do it for young people now." Sophie added: " we had a lot to fill our lives. Youngsters find it a bit boring here now" (Sophie 82). Residents of all ages - apart from today's youngsters

-recall the youth clubs of their youth. In the 1940s, according to Henry for example, there were clubs for boys and girls at the Victoria Dock mission, 7 nights a week (Henry 78). The older ones remember a variety of leisure facilities: "There's no cinema here now. When we were courting there were three cinemas, there were dancing clubs, and penny bops at the Trinity Church Hall. People complain about the youngsters now but they can't express themselves. We had Saturday morning pictures when we were children, we went skating and for walks to the docks and across the ferry to Jubilee Wood. You can't let the children wander now though... My children had plenty to do too. My son played cricket with David Sheppard." (Audrey 73). [13]

What was the neighbourhood like in post war South Canning town? One resident's comments suggested that values today had declined from the golden post war days: Bessie came to this side of the borough in 1948, when she was 18 and optimism was in the air. "The new property was built after the war. It was a new community, it was friendly, people were beginning a new life. You can't compare today with then. Its the people, their general outlook, Today its their lack of respect for other peoples well being, especially the younger ones " (Bessie 66). Some things haven't changed however. Pam moved onto the estate just after the war. She wasn't keen at first, she was "amazed that the women swore" (Pam 70s). They still do. This is one aspect of the East end culture which hasn't changed. Belinda has lived on the estate for six years, and still finds the language difficult to take. "The way they express themselves is off putting, they swear and shout, that's the way they've been brought up. Even babies in prams are sworn at".

Work

Some residents' memories of better times refer to the more recent past, a time when there was full employment. One of the most salient features of residents accounts of community life was work, local work, its availability in the past, and the lack of it now. The daughter of a skilled dockworker, Val, for example was born and bred in South Canning town: "There was work here then, the docks were going, there were ship repairers, chandlers, riggers, and factories which processed the raw goods the ships brought in. The shops were busy too . Closure was so rapid, it happened over the space of a year. Everyone knew the

[13]Several of the older residents spoke warmly of David Sheppard. One lady in her 80s wrote him a letter to say how much she'd enjoyed her association with the settlement. She didn't have the confidence to post it though, and has it still.

jobs were going, what must it have been like for those who'd always worked? By 1977, there wasn't a docker left. Now, I know people of 30 who've never worked". The closure of the docks was a blow from which the area has never recovered. Unlike mining areas, residents have (until very recently) received little help, in terms of retraining, or finding alternative work. Residents interviewed reported that they felt abandoned and neglected, and also resentful that they had been left out of nearby regeneration initiatives (especially the LDDC). They bitterly resent the government, the Council and 'they' in general for allowing the area to decline. As one resident put it: "When the miners lost their jobs, there was a outcry. When the dockers lost their jobs, no-one breathed a word" (Val).

References to a time when there was plentiful work in the area cropped up frequently in interviews with longer term residents. In all age groups, from 40 upwards the phrase "you could walk out of one job on Friday, and walk into another one in another factory on the Monday" was repeated. Even 20 years ago, jobs were still relatively plentiful. "You can't walk into a job now. You have to have a degree for a road sweepers job", (Dennis 40s). Whereas, as a 40 yr old woman pointed out: " When I left school at 15 you could get a job easily, you didn't need qualifications " (Anne). Another however was critical of the low horizons fostered in her generation : "School trained us for Tate and Lyles only. They did their best to put us off careers, " (Val 50). Plentiful local work is one reason why some of the older generation of present residents stayed during the war years. "We were evacuated to Harlow, they called us the tidal basin people. Dad couldn't stand it, because there wasn't any work in Harlow, so we came back" (Sophie 82).

Work was clearly the bedrock of the community. It helped to foster residential stability, it was a source of social contact, and enjoyment, income, self esteem and identity. There was stability and continuity: to gain dock work sons were introduced by fathers, and the many dockside factories provided a plentiful source of local work for others. Carrying on the family tradition was not restricted to dock work or to men: "Once you became 14 you either went into Silvers's, Keilers or Tate and Lyles. All of my Aunts worked in Keilers so I went there " (Sophie 82). Getting a job was an important rite of passage, and gave a much needed boost to the family income: It was as a source of self esteem for South Canning Towners and identity too. For example: "Before the war, when I started work at 14, I gave Mum my wages, and she gave me pocket money back. I didn't mind, it meant so much you see. You were proud because you were bringing something in to the family" (Sophie 82).

Being young, and being employed were happy times for many, not least for the companionship and solidarity of the workplace. For example: " I worked in a factory when I was 15, I loved it, being part of things, and we all stuck up for each other. There was music going and singing all day. For all their problems they enjoyed being there " (Chris 55). As we might expect, many friendships were formed at work (as well as in the youth clubs), and continued long after those involved left. Work also gave people experience of organising collectively, and not just through union activity. As one resident explained: "I met most of my friends at the Docklands settlement, or from where I worked. I was 30 years in Knights soap factory, and my husband worked in the docks. When I retired, they still had social evenings for ex workers. They still have outings now, the ex workers organise them."

Work, or lack of it, as chapters 3 and 4 demonstrate, has been shown to be highly important for health outcomes.. One of those few residents interviewed who were currently in work explained that work not only increased her number of local contacts, but helped foster feelings of sociability in herself too. "For me, it all goes back to going to work, meeting people. I'm used to it. That's what the young are lacking when they can't get a job. (Chris 55). Like Chris, many residents interviewed expressed strong feelings about the lack of jobs for youngsters.

Yet the literature, as we saw, suggests that not all work appears to be protective to health. Those in 'unsatisfactory' work (though it is unclear what constitutes unsatisfying or satisfying work in the studies reviewed) or who lack control at work don't do so well. Yet in the Silvertown factories, as the comments above indicate, it was solidarity with others, companionship which were the dominant features of accounts of their working life, not lack of control. It was these things which made work *satisfying*. The social aspects of work. The accounts given by Keir Hardie residents of their working lives illustrates what were for them, some of the health promoting properties of work. The contacts they made, the social skills learnt, the self esteem they derived , the support they gave and received continued throughout life, and sustained them in good times and in bad. Mavis for example, now in her 80s, met most of her friends in the factory where she used to work. They are all local, and she continues to visit them and go shopping for the more infirm. Audrey and her late husband met most of their friends in the dockside factories and the social club. Now

widowed, Audrey and her friends continue to help and support each other. Patterns of social networks, patterns of support, and their implications for health, are explored more fully in the next chapter. What is particularly interesting here is that many the benefits of work described are very much also functions associated with social networks.

Factory work, it should be remembered however, could be dangerous work. Some mentioned having to leave certain factories when they developed skin or respiratory complaints, one mentioned the dangers of lead poisoning. Others spoke of alarming incidents: " When I worked in Keillers a girl fell into a vat of boiling jam " (Ria 84) and Mavis's father was killed at 48 when someone dropped a spanner onto his head at Silvers's. (Mavis 80).

Newcomers

Past work and shared leisure activities, a strong sense of history, are the most important ingredients on Keir Hardie for creating a sense of belonging and commitment. We might expect to see differences between those established residents and the newer ones who had not shared these experiences. In such a traditional long established community as South Canning town, it can be difficult for those new residents without long term roots in the area to settle. It can take some time for a newcomer to be accepted, especially if they are "different". Social cohesion is only partial in these accounts, a conditional cohesion which has to be worked at. Vilma moved to her terraced house in 1983. "People weren't friendly at first, in this street I was the only black, but one neighbour was good. Now the neighbours are much more friendly, and I am more friendly too. We help each other" (Vilma 41). Michelle moved to the estate with her family 21 years ago: "When we first came here there was only one other black family in the street. We had a brick thrown in our window, but we stood up for ourselves, defended ourselves, and so we were quickly accepted. If you stand cowering behind the door, you become a victim" (Michelle 34). Some of the most tight knit extended families on the estate now are black families, who see themselves, and are seen by others, as real East Enders.

Newcomers may have to work hard to be accepted. This can include being prepared to defend the bad reputation of the area. " Now I defend Canning Town when people from outside criticise it. I'm getting like them round here. The only bad thing is the football team,"(June). Her boys did not agree with her last remark. They were doing their bit to be

accepted in the community - both were dressed in the West Ham strip. It is well known that the nickname for West Ham Football club- the Hammers- refers to the tools used by the boilermakers working in the docks. However, the term provides an illustration of how, as this research demonstrates, work, community, culture and leisure experience were intertwined. Now that the work element is diminished, a question concerns the extent to which these factors have become unravelled and changed. Answers are beyond the scope of this research but there is some evidence of both continuity and change in individual elements.

Some of these accounts of moving into the estate are linked to peoples perceptions of the area as a difficult place to live, of an area with a bad reputation, and how they coped. June is a white single parent from Walthamstow. She moved to Keir Hardie a year ago from an estate in Waltham Forest: "I was terrified when I heard I was coming here. Canning Town has such a terrible reputation, its the only part of the East End that's left. It has a reputation for villains, and for being a hard place to live. When I moved here, it was 2 months before anyone spoke to me. Older kids said to my kids - you don't belong here. But I made myself heard. I mouthed off a bit, said I'm staying. I came here as an outsider, and was made to feel it. Now I'm accepted, and the neighbours are very friendly", (June 32).

Attachment and cohesion

Evidence considered so far suggests that, despite a decline in services and work, and difficulties faced by newcomers, Keir Hardie can be described as a strong community. Definitions of 'community', as indicated in chapter 2, are many and various, but are generally centred around the notion that people have something in common, either place of residence, or interest. Willmott describes a third element- a sense of community. This in turn is linked to interaction with others. He uses the term "attachment community". The concept combines interaction with others with a sense of community and identity; it suggests attachment to people and to a place. One element has to do with the extent and density of social relationships, and the other, with perceptions, with the extent to which people feel a sense of identity with a place or group and of solidarity with their fellows, (Willmott, 1989).

The two strands of attachment have implications for health. Social networks, as the literature has shown, are health promoting. Perceptions of community also have implications for

health, both indirectly, in the sense that perceptions are influenced by social networks[14], but also in a more direct, yet subjective way. Though this aspect of community has been relatively neglected in relation to health in the literature, a recent American study highlighted the importance of the effects of perceptions of neighbourhood on mental health. Aneshul and Sucoff demonstrate that the perception of the neighbourhood as dangerous influences the health of adolescents, and that residential stability and social cohesion (which they define as people knowing each other) counteracts the effects of perceived hazards (Aneshul and Sucoff, 1996).

A number of identifiable factors contribute to whether Keir Hardie residents perceive their neighbourhood in positive terms, and which also contribute to the development of their social networks. The role of local work is the most important of these and has already been explored, as have leisure activities and a shared sense of history. Additional factors on Keir Hardie include length of residence, continuity of residence, housing design and policies, availability of social facilities, age of interviewees, kinship patterns, and opportunities for casual interaction. They are all factors which are associated with patterns of neighbourliness and perceptions of 'community spirit'. Opportunities and inclination for formal and informal participation are also important. All have implications for the extent and nature of peoples social ties, and, by implication, their health.

The reputation of an area can affect its residents' attachment to the neighbourhood and its people. The public perception of the area as rough, and with a high crime rate has already been noted. Yet strong community sentiments exist despite the stigmatised reputation of the place. Local people don't like hearing their neighbourhood rubbished by outsiders and despite the criminal element, the majority of residents are recognised as decent, respectable, and - when work is there - hard working people. Indeed, the public perception of the area, as stigmatised, tends not to be shared by residents, particular those with long term roots. One resident explained: "I moved away for a while, and hated it. People were so snobbish when they heard you came from Canning town, so I didn't get involved with

[14]For Janowitz and Kassarda a sense of community was found to be strongly influenced by his or her local friendship and kinship bonds and formal and informal associations (Janowitz and Kassarda,1974).

people in Romford. Canning Town's reputation was actually worse than what was actually going on. People think you'll get stabbed if you come here, but you don't " (middle aged woman). This is the Old East End, here they are fiercely proud of their history. As a relatively new resident put it :"People are very proud that they come from Canning Town. No one experienced as much as they did during the war, so I can understand it. That church survived two world wars, no wonder there was uproar when they tried to close it." (June). Because the public perception of the estate is not internalised by residents, we would not expect the negative impact on health associated with perceived hazards.

There is in any case a tendency for locals to sort out their problems themselves, and not to report crimes to police - especially not 'minor' crimes. A professional suggested that 'there is a moral code here which operates outside the authorities. An old lady can go out at 11 O'clock at night and not be mugged. If someone was daft enough to harm a local, they would be dealt with privately'. Indeed this closing of ranks, the tendency for people to 'look after their own 'emerged as a key feature of the neighbourhood, and had important implications, as will be seen later, for social networks, and for health.

Defining the spatial scale of the locality which people are attached to or not can be a problem. Willmott suggests that most people- generally- have more than one idea of the size of their community. The most local corresponds to a person's own street or block of flats and one or two adjacent ones, and most residents have some notion of a larger neighbourhood as well,(Willmott, 86). Keir Hardie residents were no exception. A resident dealt neatly with issues concerning the size of a community by comparing his block (favourably) with the Estate in general and then the estate with the wider area of Canning town: "This place had a bad reputation, but this bit here [the blocks on one side of the park where he lived] is not as bad as some. This side of the A13 is better than the other side- some places there are no go areas" (Kev). A newcomer noticed that there was a general tendency on the estate for people to make unfavourable comparisons with other blocks One of her neighbours explained: "In this block its OK, the neighbours get on fine, but the kids fight and argue with kids from the other side of the park", (Yvonne 33). This kind of labelling is probably less serious for social cohesion than divisions evident between age groups, or ethnic groups, or established residents and newcomers. Sometimes these can combine with a spatial element, as when a block consisting of predominantly young

residents who are seen as anti- social by some of the remaining long term residents. For example: "They throw rubbish over the balcony, they have a don't care attitude, they don't want to be bothered. This sort of thing creates animosity. The young people don't want to be told what to do, and that's the crux. Community in this block is nil" (Bessie 66).

At the micro scale, one woman explained that where she was living now just didn't have the same community spirit as where her Mother lived, and that she planned to move to her mother's neighbourhood. I discovered later that her mother's street was only 2 or 3 minutes walk from her home! In her case, her attachment to place was very much linked to those she most identified with.

Although some of the younger generation will inevitably move on when the opportunity is there, successive generations of families living on Keir Hardie is still a salient feature of the district, and one which residents are happy to perpetuate. [15] Decades of local available work, as we have seen, was largely responsible for population stability. Decline of employment, has not totally killed it off. The large extended family of the traditional East End community continues to be a strong feature of the area. Its reputation for crime however, and of being a bit 'rough' makes the area an unpopular place to move to from other parts of Newham. Outsiders who do move in are largely those with little choice, such as the homeless and refugees, as well as single parents. Some of the newcomers, as we saw, make strenuous efforts to become assimilated.[16].

Not surprisingly a sense of community was evident in those areas where there was continuity of residence, but less so where tenancies were short term, or where, as tenants alleged, the council were moving outsiders into the area (that is, people not born and bred in South Canning Town). One resident described her street as being in a transitory situation: " Many of the people who live in this street have been there since the houses were built in 1969. Up until about 5 years ago, we had regular street parties, and people babysat for each

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[15]For the individuals concerned, moving out of the area does not necessarily involve a loss of attachment. An elderly resident said: " My son is proud to be an East Ender, even though he has a managerial job in public administration and doesn't live here now" (Pam).

[16]8.3% of the population of the south Canning Town and Custom House area had moved into the area during the 12 months before the 1991 census. This is similar to the average for Newham.

other. Its rapidly breaking down, now that new people are being moved in." (Tessa).

Strong kinship ties were likely to be a feature of traditional working class areas like South Canning Town, where an "occupational community" such as a dockside, is localised. Some Classic community studies have pointed to the importance of the strength of the tie between mothers and daughters in working class areas of East London (Young and Willmott,1957). The large extended family is indeed still a strong feature of the Keir Hardie Estate area despite the loss of the area's economic backbone. All of those interviewed with large families living locally expressed strong community sentiments. Sandra explained how her tight knit extended family played a role in her own sense of belonging: " My brothers and sisters and my mum and dad and my husbands family - we all live within five minutes walk of each other "(Sandra 34).

Identity with the area, its work and its traditions is bound up with class identity: "People round here are proud to be working class, they tell you that Dad was a docker, and Grandfather was a docker. They don't want to be anything else " (June). Strong local family ties, as well as pride in the area, and desire to perpetuate a traditional sense of community, is not confined to indigenous white residents on Keir Hardie. Indigenous black families - who in some cases have lived in the area since before the war- express strong community sentiments too. Maggie, a black woman, explained: "I come from a large family, they all live locally. Its a strong community on this part of the estate, they are helpful, and friendly. Its like a big family, but its not as strong as it used to be. The new people moving in don't know our ways, refugees find it hard to fit in. We do try to help them though. I'm keen on the old ways, the traditional community, and I want to preserve them " (Maggie).

Those living in terraced houses, like Maggie, tended to be the most likely to speak of community in positive terms, some because they had lived there for some time, but also because streets of terraced housing tend to be neighbourly streets, terraces don't create barriers to everyday interaction in the way that some towers and blocks can. As one resident put it : "Its lovely round here. The man next door does everybody's hedges". Because such housing is at a premium however, there seems to be occasionally some resentment among other residents when widows and widowers live in terraced houses on their own. Lack of resources inevitably contribute to divisions among residents.

Some residents in low rise blocks - especially those on the ground floor- also feel positive about their neighbourhood, and especially of their neighbours. For example: "The kids may be tougher here, but my kids love it. They can play out in the front and I can sit out with them and have a cup of tea with the neighbours, or one of the others will keep an eye on them " (June). The design of the housing was important here - there is a secluded area where children can play, and June is fortunate in having a ground floor flat. Housing design - or at least being allocated a ground floor flat- can be seen here to help to sustain the traditional norm of co-operative childcare.

Housing allocation policies, as well as housing design, have also had a role to play in community life. Post war housing developments have generally been criticised for re-locating people without regard to their local social ties, with the effect of severing inner city communities, (Titmuss 1957; Atkinson 1994). Newham Council however have operated a popular -and effective- policy of re-locating old neighbours together. Barbara, who lives in a terraced house which she bought from the council, explained: "Our road is neighbourly, the majority are around the same age. I think that its a good idea for people to move in together, to grow up together , we all get on very well ". Even the tower blocks- which are sometimes seen as the antithesis of community- were neighbourly places under these circumstances. Chris has lived in Canning Town all of her life: "I've lived in this house for 20 years, before that I was in a tower block. It wasn't too bad in the tower block because it was filled with local people who had all moved out of the old houses together. The block was friendly, we all knew each other already. Then we all moved to these houses here, our children have grown up together, we've all helped each other, and we're still here". (Christine 55).

Problems occur when people who had once moved in together - as they did in one of the Towers- become a dwindling and very elderly minority. Many of the high rise blocks now have a relatively high proportion of families with young children living there, many of whom will be newcomers to the area and many of whom will be young, single parents. Housing shortages however, mean that the council has little option but to house young children in the blocks. A councillor is frequently called in to help settle disputes. " The elderly in Ferrier Point don't like change, and they can't cope with the noise nuisance and the young children living there. You can't argue with the elderly, they answer back ".

Community, according to some accounts, is a site of conflict between young and old. Comments from some (a minority) of the longer term residents suggest that the younger, and newer residents have anti-social attitudes. Bessie moved to her present block when a gas explosion in the notorious Ronan point led to all of the prefabricated blocks being demolished. She described community life in her block: "Community spirit? they don't want to live in a community. In this block the majority of young people dont want to conform to a way of life that would be expected of people living in a confined space. They are noisy, play loud music, have all night parties. If you speak to them nicely about it, you only get a mouthful of abuse. The young ones are the newcomers here, quite a few of them are single parents, some are on insecure tenancies. I don't agree with small children livng in a block, especially if the parents don't have a social way of living ".

It would appear that the younger people Bessie described had no sense of community, no attachment to place or people. They may however, have been supportive and neighbourly to each other. There may well be separate communities within the community, divided by age. Unfortunately, I was unable to gain access to any of these younger residents living in this block to find out. In any case residents perceptions can vary markedly. Another resident in the same block described relationships between younger and older residents slightly differently: "These flats were lovely when we first moved in. It was better then, we were all one. Its still quite friendly but there are not many of the old people left, the rest are young coloured people. I get on with well the new people, they say hello to me. Its a shame though that they've put babies and children in here, its not fair on the children "(Mavis 80). A resident from another part of the estate was conscious of the social isolation which can be a part of tower block life: "I feel sorry for those in the high rise buildings, once they shut the door there is no one to talk to. And to put kids in there is disgusting " (Ellen). Mavis and Ellen's accounts stress structural reasons, lack of resources, for problems and possible divisions, Bessie's focus is on declining values. Bessie also linked the general lifestyle of the younger people with crime. "Crime and drugs come into it. There have been a lot of burglaries in the block over the years. Delivery people can't leave the vans unattended while they make the deliveries. If they do, when they go down, they'll find there's nothing in the van. That's the way the young people survive, they are doing it at other peoples expense. On top of that, they smoke and drink their rent and get their community charge

paid for them " (Bessie 66). Whatever the 'truth' of all of this, if people feel threatened and unsafe in a block, it is likely to have repercussions on their health. It is also clear that parts of the estate are less cohesive than other parts, and that housing design and allocation policies play a major part in the process.

At one time, social clubs attached to blocks would help bring people together. The council has made drastic cuts in leisure budgets, and consequently social clubs and Community Centres are said to have become a thing of the past. Residents' comments suggest that these have been very important for the life of the community. For example: "When I lived in the high rise there was a club which we took the children to. Its shut now, they ran out of money, it closed 9 or 10 years ago. We played bingo, had different clubs nightly, and a disco. I made loads of friends there, and it was cheap. Lots of people round here used to use it, they often talk about it" (Lisa 33) . Another agreed: "The closure of the community centre was a great loss to the area". (Barbara) . Those who were fortunate enough to use the clubs when they were in operation have kept many of the friends they made then. Newer, or younger residents, will not have had this opportunity to widen their social networks. Pubs do not seem to be a substitute: :"You cant go to the pubs, they are not very good round here, there are too many fights" (Lisa).

Lisa's comments on her disinclination to visit local pubs were echoed by other residents. Indeed pubs - as in the whole of the Canning Town area - have very bad reputations, largely for frequent fights and criminal patronage. A governor of one on the other side of the A13 was recently murdered. Yet casual meeting places - of various kinds- are so important for the life of a community. There are perhaps fewer obvious meeting places locally than there once were.. Shops have dwindled, and the local undertakers seems to provide some of the social functions once provided by the corner shop. Some of the elderly drop in for a chat and company. Neighbours can meet in the streets and landings of course, and parents meet outside the schools. On many parts of the estate the housing design does facilitate casual interaction. However, the traditional neighbourliness of the estate, as we have seen, is said to be less evident in the tower blocks located near the A13 than it is in other parts of the estate, and the elderly in particular suffer.

Casual and superficial interaction plays an important role in helping to cement community

sentiments and also for people's general sense of well being. An individual's social networks on Keir Hardie can consist of, as well as strong ties, those which are more tenuous, and ephemeral, but nevertheless significant. As Wallman pointed out, recognising and being recognised by people at bus stops, in the street, in the shops, creates a sense of belonging in an inner city area just as it does in a rural village, (Wallman,1984, p.212). Places which create opportunities to meet will have an influence, but despite the poor provision of shops and other facilities on the estate, many residents spoke positively about just recognising people and being recognised when they went out, and about stopping to say hello. For example: "I see loads of people I know when I go out. I was born round here, went to school round here. Many of them still live here, even friends from nursery " (Masie 25). Residential stability is clearly an added factor here. Another is the nearby Rathbone market (within walking distance of the estate) which does provide a location for casual interaction, and often cropped up in conversations. Chris described the importance of the market to her quality of life. " If I'm feeling fed up I take myself down to the market, where I see lots of people. You hear some good gossip, you keep in touch with what's going on. Its not all believable, but you sort out fact from fiction", (Chris). Even strangers have a role to play in community life if the opportunities to stop and chat are there. The same resident talked about the ease with which its possible in South Canning town to talk to strangers. " Even people lining up at the bakers, although they don't know you, will tell you wonderful stories", (Chris 55).

A lack of facilities like local shops on the estate may be more significant for newcomers than longer term residents. It may be difficult for newcomers to make social contacts. They will not have the networks built up from a lifetime of living locally.

Many of the comments made by residents, including Chris, suggest that those who feel positive about the place they live in also feel positive about the people living there too. They are also more likely to mix with local people than those with negative perceptions. Social networks attach people to the place where they live, and positive perceptions foster the development of networks. Networks act as a bridge between people and places. Attachment to local people crops up as much in residents accounts of their perceptions of community as it does in their attachment to the place. For example: " community is about mixing with people. I make sure I mix with new people...Once you are known in an area,

you feel you belong " (Erin 28). "The people here are brilliant. You can have a laugh and a joke with them, they are good to you . Think how much better they'd be if they'd been given a chance" (Val).

A newcomer described her impressions of the people of the Keir Hardie estate: "They take things in their stride, they don't let things get on top of them. They have a sense of humour, but they swear like dockers - and that's just the women. As well as very colourful language, they use lots of the old phrases - like give him a cuff round the ear", (June). Not everyone shares these positive perceptions of South Canning Towners. Another of the newer residents for example found the swearing very difficult to take, and it acted as a block on her own feelings of belonging. She added: " I saw a mother hit her little toddler the other day just for interrupting her. Until I start swearing and hitting children I will not be considered an East Ender" (Belinda 43). She pointed out however, what a number of others mentioned, that their bark is worse than their bite: "Its different once you get to know people. Sometimes the swearing is just to shock, because you're an outsider. The woman next door swears, but underneath she is really nice". Getting to know people however, does take a great deal of effort on the part of outsiders, its easier for those with local roots. Perceptions of "they keep themselves to themselves" - sometimes mentioned in conversation with residents - can change too on greater acquaintance. As a life long resident said of locals: " Once you start talking and they know you're no different from them you get a different side to it all", (Chris 55).

However, there are divisions in the neighbourhood, as we have seen. The attitudes towards younger residents held by a small minority of older residents suggest that the bridges may have been washed away in parts of the estate, or at least are starting to crumble. In addition, local people can be insular, they tend not to welcome outsiders or embrace other cultures. Residents explained: "they don't want to look at other peoples cultures. There's no multicultural atmosphere here"(Tessa, 30). "Round here they wont even try other foods. 'you can't beat egg and chips they say " (June). Racist attitudes are evident, though the worst aspects of racism appear to be brought in from outside, by the BNP. A new resident is aware of the areas shortcomings: "This is a racist area, not like Walthamstow, where I come from. My friend has a half caste baby, I took him out in a pushchair, and got dirty looks down Rathbone Market - that wouldn't happen in Walthamstow. A black woman

moved into our road [on the Keir Hardie estate], she was lovely, but as soon as she moved in there was a bloke handing out BNP leaflets. Its a really negative aspect of the area and I don't like it. The woman's boyfriend was told to go back to the part of the world he came from - he's from Walthamstow!" (June 32). The contrast with Walthamstow, in the neighbouring borough of Waltham Forest, is interesting. Parts of the district are very mixed ethnically, and June's evaluation of it as a tolerant area was confirmed by a black woman living and working in Walthamstow interviewed during an earlier phase of fieldwork. In her case, she contrasted the racism she'd experienced in Plaistow with the lack of it in her new area of residence.

Racism appears to be much less of a problem for those black Canning Towners who were brought up locally. Deanna live outside the estate and had experienced racism when she had a stall in the market. She added however: "I do realise that people look after their own here. I've got relatives down the road, on the estate, they've been brought up here. They don't suffer from racism" (Deanna 27). This often mentioned virtue of 'looking after your own' is important. How residents define 'your own' has implications for support, interaction , and participation and is taken up in the next chapter.

The mutual aid and neighbourliness of a traditional white working class area like the Keir Hardie estate is tempered by insularity and a certain amount of exclusion. These attitudes, as we have seen , extend to outsiders other than ethnic minorities. I was surprised to hear a male resident complaining about "these Geordies coming down here and taking local jobs". Similar sentiments were reportedly being expressed in the 1950s! Whether less insular, more inclusive, but more heterogeneous communities like parts of Walthamstow are any less supportive and neighbourly would need to be investigated. However, as noted earlier, a resident mentioned that people where she had lived in Walthamstow did not look out for other peoples children as they do on the Keir Hardie estate. A utopian model of social cohesive community would need aspects of both kinds of communities: attachment plus tolerance and inclusion.

Participation in formal and social organisations.

The importance of conceptualising community in terms of both social networks and locality has already been stressed. Janowitz and Suttles broaden the concept of community further to include a political element. They suggest the local community creates a potential

interface between diverse interests and the opportunity to balance each against the other. (Janowitz and Suttles 1978). Indeed there has been a great deal of recent research interest in community initiatives, which aim to increase participation in decision making, in service provision, and, in some cases, help to foster shared interests and identities (Wilmott, 1989).

Earlier chapters briefly considered the likely benefits of participation in formal organisations, community initiatives and self help groups for health. To what extent do South Canning Towners join groups and organise collectively ? Despite many aspects of the traditional working class community continuing to thrive locally, participation in organisations appears limited, and in some cases is declining. Eight years ago the Labour Party for example, had 200 members in Beckton ward and regular social activities, now there are only 50/60 members and fewer social events. Most of the activists are elderly ladies (councillor).

Traditional forms of political participation appear to be declining on the estate , and we would expect Union activity to be much less prominent locally now that the docks are closed. South Canning Towners tend not to be joiners of organisations, as the Community Development Officer pointed out, participation tends to be thin on the ground in those areas where it is needed most. In any case, there just aren't enough opportunities for participation. Compared with many areas - Cathall estate for example or parts of Hackney- the local voluntary sector is not well developed, and opportunities there are often taken up by groups from outside the locality. "It is relatively easy'' commented a Community Development Officer, "to get 50 people along to demonstrate against something being closed or taken away (like St Luke's church) but to get 10 people to run a committee for a few years is another matter entirely. There are tenants associations, but these just consist of two men and a dog [17], a few dedicated people battling against the odds ". The Sisters of Mercy run projects. "Community reaching out" aims to help people to set up their own groups and projects. The sister involved finds it desperately hard to get people interested, its a long hard slog before results are evident. But, as another professional pointed out, " the hidden agenda there is Christianity and that doesn't suit everybody ". There are plans for a credit union, but people can be distrustful. They have had bad experiences of loan

[17] I discovered later that tenants associations in the area tended to consist of a small number of hard working women.

clubs, with people running off with the takings, (Priest).

A minority of residents however are highly active in their tenants associations, and in the Canning Town and Custom House Renewal Project. There are indications that participation in Tenants Associations is slowly increasing. Newcomers like Belinda and June, can be described as behaving in the manner of what Abrams described as the "New neighbourhoodism" (Bulmer 1986), though without the overtly political elements. They are attempting to create a local social world through action and involvement. Belinda, an outsider in the sense that she has only lived on the estate for six years, finds it difficult to get people interested in the Tenants Association and other organisations she's involved in: "There's no self help here. They prefer others to sort it out. They are selfish and self-centred " (Belinda). Val saw things differently, recognising that poverty and deprivation, as well as disappointments in the past, can depress the spirit: "I keep trying to instill this into the Government Office for London, people here feel helpless. You cant take away from people and then expect them to help themselves. If you are poor there is only so much you can do" (Val, TA chair).

For some, participation is another source of division between young and old. Older residents are critical of the younger peoples attitudes, of their lack of enthusiasm for the activities of the tenants associations. Pam for example "they are not joiners, they've got no get up and go, everything's put on a plate for them. They'd rather go round the rent office and get things done " (Pam 70s). Bessie is the chair of the Tenants Association for her block, where most of the residents are young people: "There's no tenants association involvement in this block. Last week we held an interesting meeting on improvements being made to the building and child safety. Out of the 115 flats here only 20 people turned up, yet there are lots of children here, and its an important issue. They just don't want to get involved , this is the general attitude. We set up a mothers and toddlers club downstairs but that fell through, it folded up after a few months. The mums couldn't be bothered". (Bessie).

For other residents, conversely, it was the attitudes of the older people which were problematic. One resident described living on the estate as like living in a time warp. "That's why its so difficult to get people involved in the Tenants Association. People are

so set in their ways, they are scared of anything new. They have attitudes which are still in the 1930s. For example, they must have their husbands tea on table at 4.30 every day."

A few younger people on parts of the estate have joined their Tenants Associations. The influence of friends is important here. Anne joined to help her friend, Val. Erin thinks highly of Belinda, who encouraged her to join, and together they try to recruit others by leafleting and knocking on doors. They've had little success. Some see lack of involvement as reflecting the "Im all right Jack" attitude characteristic of the area. Tessa believes that getting people involved in things they are interested in is the key. June has managed to recruit a few of her neighbours: "Once they see you doing things, then they will gradually join. But the older generation , the old die hards, they are afraid, they think that if you join the TA you will loose council rights. They are afraid the place may be sold of to a private developer" (June). People are used to looking to the council to provide services, and this could well go some way towards explaining attitudes, but the indications that people will join when their friends do is probably more significant and links to local attitudes of 'looking after your own'.

But large numbers of pensioners *are* active, particularly socially. According to one respondent, the elderly are the last legions of the old East End, they are organised, have a strong moral code, strong family sense, and act collectively (if not always co-operatively) The Cundy community building is run by pensioners, "...and run with military precision. They organise 5 bingo clubs, involving 200 pensioners a week. Its not very democratic but it works, even if there is conflict between leaders, and jostling for power, a shifting kaleidoscope of hate".

Importantly, interviews with elderly residents suggest that their present activity is rooted in their experiences of *work* and the neighbourhood in the past. Pam explained: "I do the pensioners club. I had 75 last time, they love it, and I love it too. Some of them have moved out of the area, but they come back here to the club. One comes by dial a ride, some by cab, they consider it money well spent. A lot of them had worked together in factories in Silvertown, in Tate and Lyles for example" (Pam 70s). According to Audrey, another pensioner active in social clubs and the Labour party, the factories , including Lyles, had their own social clubs . Today's pensioners, I discovered, are simply continuing with a part

of their lives which has always been important to them. The clubs' organisers are the same people who used to be involved in organising social events in the factories and other workplaces. They are also people who participated in youth clubs and other social activities in their youth.

Workers involved in the Custom House and Canning Town Community Renewal Project (CH&CTCRP) are all too aware that the way of life typified by the pensioners acting collectively and co-operatively, is dying. Literally. They aim to re-create it - 'the old East End' via the project. The St. Luke's projects will provide GP surgeries, space for small businesses and voluntary organisations, a new community hall, training, a childcare practice and training centre and a homecare co-op. They have received money through the European Regional Development Fund and will provide 189 jobs. If the project is successful, and encourages participation, it is certainly likely to improve the health of the individual and the community, in particular, by providing a focus and location for activities and services, and by facilitating social interaction. [18]

The importance of work in fostering local ties is clear. Evidence on neighbourliness, attachment to the community, local extended families, continuity of residence and activity in pensioners clubs suggests that these ties have sustained the substance and sense of community into the present. But how sustainable is the community without work? How long before the social organisation of the area - which grew from structural factors- breaks down? The reported lifestyles of some of the young people on the estate (though admittedly not fully researched) is an indication that the social organisation is weakened. Work is not the sole factor influencing community life of course. Many others are indicated- housing

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[18] While the St. Luke's project is the largest of CH&CTCRP's activities, they run three further schemes:
1) Pitstop, a motor-mechanics training scheme run from a bay of vandalised garages let by Newham's Housing Department in 1993. An education worker provides weekly literacy classes to some of the trainees.
2) The encouragement of a greater variety of community activity, particularly with groups for children. An early learners scheme for 5-7 year olds has been running since 1995. A part time worker funded by Aston Charities Community Involvement Unit will work solely on the development of small scale, long term projects involving volunteers.
3) The Garden Project, a summer environmental scheme which began in 1993, for young people to transform the wasteland on the site of the old Ashburton school into a nature reserve for local people.

policies and design, clubs and leisure activities, local shops and facilities, becoming involved in local activities. However, some of these, like work, are not available to the extent that they once were. Strong positive perceptions of community held by residents suggest that the estate has been remarkably resilient in the face of so much neglect. But the question remains, how long will it remain so without considerably more extra resources and help, and jobs. Already the cracks are evident. Divisions between the older generation of residents and the younger ones are the obvious example. Changes in values and attitudes may be part of the explanation, but structural factors- the scarcity of suitable housing for example- is a major contributory factor. These points have important implications for health. There was a clear divide on Keir Hardie between the opportunities available to the over 40s to lead a healthy life when young- and today's younger people. The over forties had jobs, clubs, leisure facilities, more meeting places when they were young. If these trends are replicated at district level, then they are likely to contribute to the pattern of worsening health of younger people identified by the Health Authority.

Keir Hardie does not have a high level of participation in formal and formal organisations amongst residents generally, although the social activities of pensioners are clearly an exception, and evidence on tenants organisations is a sign that participation may be slowly increasing. I argued elsewhere that an important ingredient of a healthy, positive community was a high level of participation born of solidarity (Cattell,1995). A general distrust of outsiders, and those who are different, including ethnic minorities, suggests that solidarity- recognising shared interests with dissimilar individuals and groups - is not a strong feature. The estate cannot be described as a community of solidarity, though the relatively high number of locals involved in protesting against the closure of St. Lukes Church are an indication of the potential. What is interesting here is the local notion that you "look after your own." How people define "their own" is important - important for individuals social networks, for their attitudes to community, and to their health. This will be explored further in the next chapter.

This chapter, in focusing on factors associated with the Keir Hardie estate as a community, has looked at how those factors relate to social networks. It has however, looked at social networks in only very general terms. The next chapter will consider patterns of Keir Hardie residents' social networks in more detail, and examine ways in which social networks can

affect health. It will further examine aspects of the social organisation of the estate, in particular, by considering the extent to which networks continue to provide support and other resources and under what conditions they occur. In particular it asks, can patterns of social networks be identified? Do different kind of networks bear different relationships to health ?

8. SOCIAL NETWORKS AND HEALTH OF KEIR HARDIE RESIDENTS

Introduction

The last chapter identified local features of the Keir Hardie estate which affected community life and influenced opportunities for forming and developing social networks. It referred to social networks in a general sense; this chapter looks at social networks more closely. It examines the networks of individual residents in terms of the characteristics and components of their networks. It asks:

- Can we identify different kinds of networks according to the characteristics of the people in the network and the structure of the network?
- Do different kinds of social networks affect health in different ways? Do the health promoting or damaging functions of networks vary according to the different kinds of network?
- Do different kinds of networks enable people to cope with poverty and deprivation in different ways?
- Is there a relationship between kinds of network (network formation) and attitudes and values, including those which can impact on health, such as hope for the future, fatalism, or despair? Do perceptions of community vary with different kinds of networks. Do attitudes to inequality have a role to play?

One of the key characteristics of South Canning Towners which emerged in the last chapter on community was the value of 'looking after your own'. One of the questions considered in this chapter is whether this value varies with network type, and whether there are implications for health. Another is, how do people define their own?

Network models have been constructed as a means of accessing information simultaneously on the characteristics of the individuals in the network, the structure of the network, and the functions that networks provide, including those which are beneficial or otherwise to health[1]. The network models adopted here are grounded in the interviews themselves, not in the literature. They represent an attempt to construct ideal types. They refer principally to the degree of *similarity or dissimilarity* of a network, estimated with reference to the range of membership groups which make up the network. Membership groups will include family, ethnic group, neighbours in the street/block, people in the wider community, school friends, people connected with work- present

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1 Weber uses the term 'Ideal type' when referring to models. Ideal types are "a pure type, constructed by emphasising certain traits of a given social item which do not necessarily exist anywhere in reality. The traits are defining, not necessarily desirable ones", (Giddens,A, *Sociology*, 2nd ed 1993, p. 755).

and past, clubs, organisations. Membership groups are a useful analytical tool because they encompass information on both the characteristics of the people in the network and the structure of the network. Models will also refer to reference groups. These will include Canning Towners, East Enders, social class, ethnicity, rich/poor. Reference groups are useful here in looking at attitudes, values and identity, and perceptions of shared interests, and also because poor health has been linked to perceptions of inequality, as well as the reality of inequality.[2]

Within the models I look at processes which affect health. Links are examined between types of relationships, and aspects of network structure - particularly the degree of connectedness (density), and differing functions of networks - eg support, values, esteem, control, identity, companionship, access to resources, and how these interact to affect health in particular circumstances. Although tendencies can be observed - particularly at the two extremes- in the relationship between network models and illness and health, the models themselves do not bear a direct relationship to health. They have been adopted here as a way of accessing and understanding complex processes and interactions, and of identifying concatenations.

Health outcomes are a result of the interplay between these various factors, as well as deprivation and behaviour, all mediated by time and place. The models seek to demonstrate how different network formations can affect health in different circumstances, and can help people to cope with poverty and negative life events. The underlying assumption is that networks act as mediators between poverty and ill health, in both a positive and negative way.

THE MODELS: A TYPOLOGY

The network models which relate to the social networks of Keir Hardie residents have been classified as certain types: *Restricted; Similar; Traditional;Pluralistic,* and *Network of Solidarity*. A *Developing Network*, refers to residents whose lives and networks were undergoing a process of change at the time of the interview. In summary, the individual components and attributers of each

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2 Bott used the term membership group and reference group. The concept of "reference group" refers to any group, real or fictitious, employed by an individual to evaluate his or her position with that of others. S/he may belong to the reference group, or may not. Reference groups may be positive or negative, the individual will adhere to the norms of a positive reference group, but not to a negative reference group. In forming their attitudes and beliefs, and in performing their actions, people will compare or identify themselves with other people, or other groups of people, whose own attitudes, beliefs and actions are taken as appropriate measures. Bott,1957).

network are:

	RESTRICTED	SIMILAR	TRADITIONAL	PLURALISTIC	SOLIDARITY
Membership Groups	Few	Small number, family & local friends	Family, neighbours, ex-workmates, friends from clubs	Large range, made up of dissimilar groups	Wide range, similar and dissimilar groups
Structure	Small numbers in network	Dense, tight-knit, size varies	Dense, tight-knit	Usually loose-knit	Both dense and loose
Attributes	Isolation Low self-esteem Low control Few sources of support	Sense of belonging, identity Network supportive but could be controlling	Can rely on great deal of support, sense of belonging, identity.	Perceptions of control. Self esteem Sense of achievement	High level support and access to resources. Self worth, esteem, control and identity
Health	Poor	Varies. Quality of relationships with network members significant	They cope with it	Usually good	Usually good
Attitudes	Political cynicism Fatalism Lack of hope	Fatalism Pessimism Political cynicism	Predominant value of coping, tempered with fatalism	Optimism, desire change, see role for themselves in process	Optimism, vision of hope, social consciousness and tolerance
Negative Reference Groups		Outsiders; Other ethnic groups			
Positive Reference Groups	Few in some cases	People similar to self, eg family,Canning Towners	People like self, including Canning Towners, working class		Wide range
Examples	Newcomers Isolated elderly Unemployed Women with children & a domineering and/or violent partner	Parents of young children (inc. single parents) with family living locally. Adult living with parents, working locally. Unemployed	Elderly, born, bred and worked locally	People involved in voluntary organisations, maybe newcomers	People with strong local ties of family/ friends, plus active in organisations & self-help groups

The network types identified here are loosely connected to (though not wholly determined by) some of those features of community life in Keir Hardie highlighted in the last chapter. The 'Traditional' network, for example, is that most closely associated with the traditional working class community of which elements are still identifiable on the estate. It is characterised by experience of local work, strong local family ties and long residence in the neighbourhood, and strong attachment to the community. The similar network is perhaps associated with a traditional community which is less strong than it was. The local ties, particularly family ties, are still there, but the members of this network tend not to have experience of work, or the social clubs which used to be a feature of the area. In a sense it is *more* parochial than the traditional community, networks are insular and inward looking. The Restricted network - in some cases - could be seen as evidence of a decline of values, of community breaking down, but the picture is complex and the model incorporates a wide range of people who, temporarily or long term, have restricted or truncated social networks. Both structural and personal factors have a role to play in the Restricted network. Both the Pluralistic and the Network of Solidarity to some extent reflect opportunities for participation in organisations, but the latter has also grown from the traditional community - people with these networks have a strong sense of belonging to the area and a strong sense of history.

The key feature of these models - based on the range of membership groups in the network - is that **the functions which networks bestow and which the literature suggests are health promoting, vary according to the network model.** The range of membership groups in an individual's network has implications for the mechanisms involved in the relationship between social networks and health. Health promoting functions of networks suggested by the literature, such as support, identity, access to wider resources, perceptions of control, self esteem, and health protecting or damaging attributes or attitudes, such a hope for the future, fatalism, pessimism, are closely related to network type. The relationship between network model based on membership groups and reference groups, and health, is not a straight linear process. All models, except the most restricted, have the potential for some health promoting attributes.

THE RESTRICTED NETWORK

The restricted or truncated network is limited to a small number of membership groups, and a relatively small number of people within that or those groups. Because the numbers of people involved in the network are small, density (degree of connectedness) is not a useful way of looking at these networks. Individuals whose networks correspond to this model are very dependent on network members . The quality of relationships (in terms of the contribution they make to the

functions provided by social networks) in the restricted networks model is the more crucial for health than the other network models.

People whose networks corresponded to this model reported experiencing a number of characteristics which the literature has associated with poorer health such as feelings of isolation, lack of self esteem, and lack of control. There were few people they could rely on for support. They also spoke of experiencing poor mental health and stress related physical illness, all exacerbated by lack of financial and other resources. They were also likely to express attitudes of political cynicism, they were fatalistic, they lacked hope and had few aspirations for the future, attributes generally associated with poverty.

People on Keir Hardie whose networks corresponded to this model included newcomers; unemployed people, women with controlling or violent partners; and some isolated elderly people. Many people find that their networks are restricted at certain points in their lives. They may spend much of their time at home through age or infirmity, they may be disabled, new to an area with young children, or experiencing ostracism from neighbours. Unemployment, and especially long term unemployment, can also act to truncate an individual's social ties. As a transient situation, being new to an area probably has the least serious implications, and the isolation associated with it easiest to overcome. Similarly, because of its transience, and because people are not so locked into the model, other characteristics associated with this kind of network tend not to be evident in newcomers. Although not many in this category were interviewed on Keir Hardie, (there were more newcomers on Cathall) several mentioned how isolated they had felt as newcomers. For example: "When I moved here from North Wales, I was told people would be hostile as soon as I opened my mouth, because I wasn't an East Ender, so I kept myself to myself. For quite a while I only had contact with my immediate neighbour. After a while I realised this was silly, and I started to get involved in a play group. I then realised that people were not hostile at all, but very friendly" (Belinda). Her comments illustrate what was noted in the last chapter, that strong feelings of local identity can act to exclude those who are not seen as belonging. Another woman explained how she dealt with initially hostile neighbours: "When I moved here (from Walthamstow) it was two months before anyone spoke to me. Other kids told my kids - you don't belong here. But I made myself heard, I mouthed off a bit, and told them I was staying, and I got accepted" (June).

Some of the elderly in South Canning Town reportedly have very restricted networks, and may lead isolated lives. Their very isolation, however, makes access difficult. Bessie spoke about the situation in her tower block: "There are a lot of lonely old people here. If I was to knock on doors

I wouldn't get an answer, even if they are in, because they are afraid to open the door. They have been warned to be careful who they open their doors to. There have been bogus gas and electricity callers for example, so I understand their behaviour". I have had to rely largely on second-hand accounts for this group. Those faring the worst seem to be elderly people with several at risk factors - families not living locally, for example, no family, a fear of crime, or, in a few cases, "keeping self to self" attitudes. It is interesting that when those factors which we associate with a traditional working class community - like a local extended family - are no longer there - then an individual's local social world can crumble. This will be particularly true where other aspects of social and structural change - as we saw in the last chapter - act to hamper social interaction. When features like these are combined with unhelpful housing conditions, then the elderly as we also saw earlier, can be in a highly disadvantaged position. Neighbours, as well as other local contacts, are especially important for the elderly. It has been shown elsewhere that the childless elderly in particular have networks which are strongly located in the neighbourhood. (Broese Van Groenon,1995). When conditions for neighbourliness cease to be favourable, this group in particular will suffer.

Their isolation may be exacerbated by their retention of traditional 'keeping self to self' and 'looking after your own' attitudes, even when their social world has narrowed. A resident who used to be a home help described some of the people she used to help: "There were many isolated people in the blocks in Rathbone street. Some were too ill to go out, but some made themselves isolated, they wouldn't go out to the club for example. One old lady was only one year older than I was. She couldn't cope when her husband died, and she had no children. I tried to bring her out of herself, but I couldn't. She was just really frightened to go out." Despite the efforts of a few committed people, there appear to be few sources of support and contact for the elderly living in the tower block mentioned in the last chapter, where a dwindling number of original, elderly tenants, were outnumbered by young residents. Bessie explained: "We do try to keep an eye on our vulnerable elderly We've had some nasty incidents over the years- people have died and no one knew. There are three or four people in their late 80s in this block. Their families have moved away, so in an emergency they would have to ask one of the other elderly people to help, or I would do it myself". What is striking in this account is that support is not expected to be forthcoming from other, younger residents. All of this may well be evidence of a breakdown of traditional values of mutual aid amongst younger residents. Yet, housing allocation policies, small numbers of elderly, together with a style of housing which makes interaction and access with peers difficult act to suppress this essential mutual support aspect of neighbourliness.

Lack of support is not the only thing they are likely to miss out on. The isolated elderly may be deprived of the other benefits which social networks provide, such as companionship, access to resources, identity, feelings of belonging etc. Tessa described the lives of her elderly parents, whom she lives with. She is their main - perhaps only- source of support and companionship. They don't provide these things for each other. "They've been married for 55 years, and they don't talk to each other. I have to mediate between them. You either laugh and deal with it or end up in a white jacket with your hands tied round your back." Tessa realises that her parents need help, but has found it difficult to arrange anything. "Its difficult to get Mum to go out, she's really down, and thinks she is incapable of doing anything. I tried to get the doctor to refer her for counselling. He said 'Its not worth it at her age, at 73 she won't change'. But I don't agree. You can't change your doctor though because no one has room on their lists. I have the resources to go elsewhere, but many of the elderly don't have someone to push for them, and they won't push for themselves. In any case the state has always done everything for them for 40 years, they don't know about anything else." She also described how powerless elderly people as a whole can feel: The council for example, "keep asking for rent money, although its been paid. Even though its just a computer error, some elderly people will pay up", (Tessa). Being afraid to challenge those in authority, will have a detrimental effect on anxiety levels and health.

The very elderly, the frail and infirm, will, due to mobility problems, experience more restricted networks than they did during earlier phases of their lives. Amy (90) and two or three friends meet nearly every week in the Methodist Hall. She explained what she liked about it: "I'm happy when I'm sitting here. I like to listen to the others talking. If you have a health problem you can tell the others about it."

These meetings are clearly very important for Amy and her friends. Normally, Amy only goes out if her daughter can take her - even to the doctors. Her comments suggest the importance of *regular* social activities for the very elderly, and of help with getting there. They don't have to be frequent, but their regularity gives them something to look forward to. This in itself is likely to be protective to health. Regular events give structure and a timetable to our lives, as work does for those of working age. One of the aspects which emerged from residents' (of all ages) accounts of their lives was that not having anything to look forward to has a negative impact on their sense of well being. These comments emphasise the importance of appropriate services for potentially isolated groups. Although not investigated here, it is possible that isolated elderly people for example will be receiving services, which not only give structure to the week, but which also, in a small way, keep

them in touch with the outside world and other people. Meals on wheels for example, community nurses, and home helps are obvious ones.

We tend to associate childhood and youth with lots of social contact, but it wasn't so for 30 year old Tessa. She contrasts the extensive and varied network she has now- contacts made largely through her job- with her childhood. "I felt isolated as a child, and in my teenage years. I was unhappy for most of my school life, I didn't fit in, everyone was in gangs, I was bullied. I link my bad health as a child with the fact that I was not happy at school. I played on it a bit. I had regular stomach upsets and migraines at school: it was pure stress." Tessa lives with her elderly - and a little difficult- parents. She is very supportive towards them, but I suspect gets little from them.[3] Even when she started her first job, at a chemists round the corner from where she lives, it did little to open up her social world. "Everyone who came into the Chemist was from round here." A spell of unemployment brought health problems- chest problems and mild depression. An interesting job has opened up her network, and her health has improved accordingly.

A much more extreme example of a severely restricted network, and one which appeared to be not uncommon on Keir Hardy, concerns the woman with young children, and a domineering and or violent partner. Such women reported experiencing a number of characteristics which the literature has associated with poorer health such as feelings of isolation, lack of self esteem, and lack of control. They also spoke of experiencing poor mental health and stress related physical illness, all exacerbated by lack of financial and other resources. They were also likely to express attitudes of political cynicism, felt fatalistic, they lacked hope and had few aspirations for the future. Their positive reference groups were also limited.

Individuals in this group, as we would expect where social interaction was limited, were unlikely to feel a strong sense of identity with where they live. Heather (33) lives just outside the estate, but spends a lot of time on it- at Newpin. She is quite new to Canning Town, and doesn't like where she lives - a flat on the other sided of the A13. "I used to be frightened to go out at night, because of the muggings, the drugs and the break ins, and the kids robbing cars". She is critical of her neighbours: "Their kids swear and pick on my kids, and they keep pressing the buzzer, and they knock and ask for food. I tell them to ask their own parents. My kids' behaviour has deteriorated. They have picked up some bad habits and head lice since they moved here." Although she shows

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3 Rogers found that never-married individuals who live with their parents have a particularly high risk of mortality. He suggests that this may be because they provide their parents with instrumental support without receiving emotional support in return (Rogers, 1996).

little attachment to her territorial community, she now has a new membership group - and interest group- at Newpin, on the Keir Hardie estate.

When networks are restricted, the quality of the relationships of the contacts the person does have is clearly very important. A non-supportive partner for a woman with young children for example, will have greater implications for health effects than it would for a woman with many contacts. When women in this group spoke of their health, they spoke of relationships Denise hated the Keir Hardie estate when she moved here ten years ago, because she didn't know anyone and because Canning Town had such a bad reputation. At the time, she also felt isolated for another reason: "When I was living with the kids Dad, I suffered from depression. I'm much happier now, I've got brilliant neighbours and he's in prison". Kim too had a difficult time with a violent partner. In his case, prison improved him and he's much more supportive, especially with the children "He'll do anything now, he even gives the children their tea".[4]

Maggie is a very friendly, outward going person, but she hasn't always been like that. When she was in a bad relationship, she had few contacts and her self esteem was rock bottom:

> "When I was living with this violent man, I suffered from stress - it was emotional, mental and physical stress. I had no self esteem, I was made to feel the lowest of the low. I've survived though, I've come out of it the other end. I felt suicidal at the time, but the kids kept me going. If it wasn't for them I wouldn't be here."

Maggie's physical health suffered also. "I had to call the police, he tried to strangle me a week after I had the throat operation- it was my thyroid, caused by stress. He threatened to kill me . The kids were afraid of him. I had to dig deep to stand up to him and get rid of him. When he went it was like a weight being lifted off. I mix much more, and I intend to go right to the top".

Maggie now has a part time job and helps as a volunteer at a local school. Maggie, and some of the other women I interviewed, were clearly better off in terms of health and well being than they were when with a partner who was violent. It is difficult to appreciate the comments of some of those who see the growth in single parents as evidence of a break down in family values, and as evidence of a growing underclass. As single parents they became much more integrated into the community, and its values, not cut off.

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[4] Hilary Graham has suggested that women can be particularly reluctant to challenge the domestic division of labour in relationships where violence is a constant undercurrent. (Graham,1993, p.100).

The partner's desire for control, and the womens' feelings of powerlessness, are a dominant theme of these accounts. Heather's (33) health ".. used to be alright 'till I married. He is a violent man, he drinks, he threatened me with a knife, he tried to kill me. I've left him, but its difficult to feel free of him, he still tries to control me. He still sees the kids, and that's a worry. He got arrested when he took them on holiday. I'm a bag of nerves. I've been on depression pills and stress pills". She makes frequent visits to the doctors, but finds that stressful too due to the long waits involved with fed up kids. Deanna is in a new relationship: "I'm not in control at the moment. I've got into something I can't get out of. I met someone, I jumped into it head first. Now I realise he's on hard drugs, and he wants me to go on them. Its affecting my son, he's sullen now. My sister tried to warn me, but I had no experience of hard drugs" (Deanna).

These women were in situations were there were few sources of support available to them. The interviews suggest in any case that there appears to be a reciprocal relationship between a difficult partner and few contacts: the former may act to restrict the latter. Maggie explained how isolation made an already bad situation worse:

> "I was very isolated. I wasn't allowed to have friends or family round. He had control over me. The situation wouldn't have been so bad to cope with if I hadn't been so isolated. One neighbour was allowed in though, and was made welcome, but it turned out that they were having a relationship".

Vilma now works and is very active in a self help organisation. She felt very isolated when she was married however: "My husband is not a friendly person, he fights with anyone, and used to make my friends upset, so that they did not like to visit. If you had come here when he was around, you would not have been happy to sit down ".

Jackie's (53) experience was similar to Vilma's but in her case she put up with a violent husband for a long time. She lost contact with friends and family and her health suffered:

> "I was married to a violent man. I wasn't allowed out, I wasn't allowed to speak to neighbours. I lost contact with my brother. I felt terribly isolated, and had little confidence then. I'm always over the doctors, because of depression, and I've had arthritis for 10 years. I was worse when I was married, I was on Valium and found it difficult to get off them. That part of my health has improved over the last few years, since I've been on my own and involved in the Tenants Association. I feel in control of my life now, I didn't before".

Already restricted networks can make the situation people later found themselves in particularly difficult to cope with. Jackie's network had already started to contract before she was married: "My Mum died when I was 22, I had to work part time so that I could look after my little brother. I was the only girl, none of the rest of the family helped. I gave up my social life when I was 22." Her

comments, as well as Heather's, suggest that childhood experiences of isolation may also impact on current network patterns. Apart from the children, Heather's main family tie is her mother . Her father died when she was 12 and she is not in regular contact with her sisters. She doesn't know many people locally. Kevin was abandoned as a child. He has few contacts now and his physical and psychological health is poor. These interviews, as well as confirming relationships between poorer health outcomes and low control, and low self esteem, illustrate how the death of a parent when young can affect present social networks.[5]

Even when relationships with immediate family are good, they may be unable to provide enough help and support to make up for overwhelming problems and restricted social networks. Growing problems and diminishing social contacts, may, in any case, develop in tandem. Housing, for example, if it acts to restrict opportunities for neighbourliness, can restrict networks and exacerbate feelings of isolation. Kevin has had to struggle with many problems, including a heart murmur. Although he has a good relationship with his wife and young children, he has few other social outlets. "I cracked up when I lived in the tower block in Stratford, I felt so isolated, it was like a cell. There were eight other people on the landing, but we never saw them, it was like a ghost town".

Although, now living on the Keir Hardie estate in better accommodation, it is still totally inadequate for the needs of their large family. Kevin and his wife cope admirably with their children. Kevin's background and circumstances are such however that he can rely on few avenues for support and help:

> "I'm unemployed. I can't read or write, I did labouring years ago. I've been on courses, but nothing ever happens, its always the man next to you that gets the job, the man with qualifications. I never went to school when I was young, I bunked it, my family didn't care. I'm stricter with my kids. Dad chucked me out when I was 11, after Mum walked out on us. I lived on the streets for three months. Dad never reported me missing, he didn't care. He was always in the betting shop, and the old girl - she always had a bottle of brandy."

Despite Kevin's success at coping with his own children, his health has suffered, particularly at times when "life events" strike. "I had depression two years ago, I couldn't stand the pressure, and my marriage nearly broke up. The doctor gave me pills when her [his wife's] Dad died, I got on well with her Dad". Pressures can build up in other ways, and affect relationships with neighbours: "I got into trouble from fighting with the bloke downstairs 2 weeks ago. I'm waiting to see the

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5 Brown and Harris demonstrated that death of a mother before 14 increased a woman's vulnerability to depression when life events strike in adulthood (Brown and Harris,1978)

police".

Friends have generally been shown to be important sources of emotional support. Kevin has had little opportunity to form many contacts. Some of the usual sources - childhood, school, work, leisure activities- were truncated or non existent. He is not a joiner of clubs, and wouldn't be able to afford them if he could, and like many working class men would be unlikely to get involved in formal organisations. There are few opportunities for people (especially men) to socialise in the area, local pubs, as we saw earlier, are generally seen as undesirable places.

Kevin's experiences illustrate graphically the combined effects of curtailed social ties and disadvantaged circumstances - such as unemployment, poverty and inadequate housing - on his health. His experience also illustrates how personal disadvantage over a lifetime has been compounded by the recent social economic change which have acted, as we saw earlier, to restrict opportunities on the estate. If, as Gaillie, Gershuny and Vogler have suggested, the effects of unemployment - including poor psychological health - are heavily mediated by the social location of the individuals experiencing it, (Gaillie, Gershuny and Vogler 1994) then in Kevin's case, his social location, his social isolation, is in part a product of local circumstances, and in part a lack of social and material capital.

Families like these need help and support, before multiple problems totally overwhelm them. Twenty years ago a man like Kevin would have found unskilled work easily enough in the dockside factories.

Attitudes and reference groups

A limited number of positive reference groups can be a characteristic of this restricted network model as well as restricted membership groups. However, for some of those interviewed in this group, their isolation was short lived, and to some extent artificial, and therefore restricted positive reference groups are less of a common feature of this group than of the Similar model examined later. Nevertheless, racist attitudes, irrational fears, are apparent in *some* of those people whose networks are restricted now, but not evident amongst those interviewed who have experienced restricted networks and isolation in the past.Heather for example is distrustful and fearful of people who are not like herself: "Britain isn't really fair, you're too frightened to open your mouth with Asians and coloured people. It would be nice to go somewhere where they are all white. If a coloured man walks past and I look at their face, it frightens me, I drag the kids away."

In the last chapter it was noted that people's irrational fears of black people allegedly extended to distrust of those working in the General hospital and may possibly act as a block to seeking treatment. It is interesting to note here that these kinds of racist attitudes are more likely to be found amongst people whose networks correspond to the Restricted or Similar models than the other models - though they are to a lesser extent evident in the Traditional group as well.

One of the most striking characteristics shared by many of those whose networks are restricted is a total lack of hope for the future . As Kevin put it: "What future? There's no future for anybody. I live day by day". A lack of hope, as we have seen, is a feature associated with deprived urban areas of the 1980s and 1990s. Here, it is closely associated with the individual's social networks.

DEVELOPING NETWORKS

For most people, the restricted network is not something they will remain locked into for any length of time. The elderly are an exception. For others, it is a pattern associated with a certain phase in their lives, or point in the life cycle. Services can be an essential feature in helping people to develop their friendship and support networks. As we saw in the last chapter, the area is not well provided with services. Nevertheless, respondents' experience illustrates the importance of policy interventions in expanding people's networks, as well as helping them cope with problems and children in difficult circumstances, and by extension, protecting their health.

Life is beginning to improve for Heather, and her health along with it. A new partner and her involvement in Newpin are reducing her isolation, widening her networks and providing her with much needed support. Of the partner: "he gave me £20 to go out tonight with the other girls", and of Newpin: "I've been coming here since June, I really like it; I come here every day. There are other people to talk to, I listen to their problems, and, if I have a problem, I expect them to listen to me. It helps my depression, I haven't taken tablets for 2 days. If the kids are wound up I still get angry though. I used to be a shy person, but I've come out quite a lot since coming here." Newpin clients are from a variety of ethnic groups. It would be interesting to see if her experience of mixing with people different to herself would, in time, change her attitudes to ethnic minorities (already described) in the direction of more tolerance.

Some residents described the kind of networks which they were currently part of, and contrasted these with those of the past. In some cases, their networks were undergoing a process of transition

at the time of the interview. Deanna is a 27 year old single parent with one small son. She has lived in nearby Beckton for a year, and visits the Keir Hardie estate regularly when she comes to Newpin. She does not know many people where she is living, and feels isolated. She used to have a stall in Rathbone market, (very near the study area) at one time. So we would expect her to have local contacts. She was not included in the membership group of stallholders however, and experienced racist behaviour from other (white) stallholders. "Once, a fishmonger, threw his dirty water on our stall".

Newpin however, is making a real difference to Deanna's life, and helping her to cope with her problems (including a partner on drugs) and develop her networks. "I feel a different person now, I get out more, I know more people and feel more confident." They also helped her to cope with bereavement by supplying the kind of emotional support her networks were unable to provide:

> "When Mum died the workers here supported me, they were there for me night and day. I feel stronger now, feel more in control, and my family come to *me* for support, I've taken over Mum's role" .

Parents isolated circumstances can affect the well being of their children, and children can become very dependent on their mothers. Deanna's son enjoys coming to Newpin, where he can play with other children."Where we live there are no children, and because its a flat, he has to be quiet, here he can run around".[6]

SIMILAR NETWORK

The similar network consists of a relatively small number of membership groups, but there may (or may not) be extensive contacts within those groups. The networks are dense/ tight knit, ie the

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[6] Mothers come to Newpin to receive support and advice on parenting when families are in difficulties and children are vulnerable. It was set up in the 1980s when it was noticed that many young mothers in Southwark were suffering from depression, and that child abuse figures in the borough were higher than the national average. Its director, Anne Jenkins Hansen, is convinced that we can no longer rely on the automatic transmission of good parenting, and that intervention has become increasingly necessary with younger parents. She believes that the growing tendency for relationships to break down together with growing economic uncertainly all threaten to engulf some families. Once a woman has agreed voluntarily to come to a Newpin centre with her children, her self esteem will be built up. She is given the chance - a chance which she may never have had- to take control of her own circumstances. At the same time, babies and young children learn to socialise, and learn to lose the chronic dependence on their mothers which is a feature of many cases. (Cunningham,J "Mothers Little Helper", *The Guardian*, 23.10.96).

individuals in an network - made up largely of family, plus some local friends and neighbours - know each other. An individual's positive reference groups are likely to consist of people seen as similar to oneself. Examples include what I will call the 'Proximate family' or what Willmott refers to as the Local extended family.[7] Most of the cases in the 'Similar network' model fall into this category, many of whom are single parents. Other examples could include a network made up of neighbours and friends who are one and the same. People whose networks correspond to this model usually have a strong sense of identity, a strong sense of belonging to group or place. This network model, along with the traditional model described next, is quite typical of the social networks of Keir Hardie residents. Both are linked to the stability of the population, continuity of residence and the strong kinship ties typical of the estate.

Some of the characteristics of this model will be protective to health, some not. The quality of individual relationships within the network - in terms of the functions they are able to provide - are important for this model, though not as important perhaps as they are in the Restricted model, where very small networks make network members particularly dependent on each other. The Network may be very good at providing practical support of various kinds, in some cases it may be good at providing emotional support, and will almost certainly confer a sense of belonging . However, in some cases the network may be to some extent controlling, individuals may perceive a lack of control over their lives, they may feel that their options are restricted, attributes which are likely to have a negative impact on their health.

Jennifer's (48) network structure is typical of this group and the Traditional network described later. Her network is very dense and localised, her daughters and one of her brothers live very near. "The kids know my friends, everyone I know they know" . Neighbours used to be very important for Jennifer when she lived over the other side of the estate, but friendships made then do not seem to have stood the test of moving. "My house was an in and out house where we lived before [at the other end of the estate], drinking tea, laughing smoking, then a quick rush round before the old man got home. When I moved here, those I thought friends hardly bothered to visit, it was too far for them, so I thought I'm not going to be like that here". Her comments are illustrative of Alan's ideas, discussed in chapter 4, that working class friendships are restricted to certain contexts.

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[7] Willmott describes the local extended family as typically made up of the parents and one or more of the children and their children. The link is characteristically through women and their daughters but mother in laws can be involved as well. Physical propinquity and every day contact is its basis. (Willmott,1986, p 26)

Unfortunately, as we saw in the last chapter, opportunities for forming friendships on the estate and the surrounding area have diminished in recent years.

Deb is 41, one of the few interviewed employed, and is buying her council house. Although a single woman who does not have children, Deb's networks, like the others in this model, are family based, very dense and totally localised. She mixes mainly with her family, and a local friend who knows her family. She works as an assistant in the local library, but because other library staff do not live locally, does not mix socially with colleagues. Residents in this group share positive perceptions of their community. Deb is glad to be part of her local community: "Locals come in here and chat, and they see me when I go shopping and recognise me". Her remarks emphasise the importance of the market as a venue for casual meetings. "At lunch time I go to the market, they all know me there." Similarly Kim, Julie and Kathie, all single parents, are strongly committed to where thy live - to South Canning town generally, as well as to their own blocks. Their networks are certainly homogenous. Although they" know everyone" in their immediate area, the neighbours they mix with tend to be the same ages as themselves, and white, like themselves.

Those who are mothers of young children in this group tend to receive a good deal of support from their own mothers and other family members. Diane for example is a single parent born locally with four children including baby twins, Her mother is very supportive, providing financial and practical help with the children, and comes over every day to help. In another case, until her death last year, Anne's mother was a great source of practical and emotional support and Anne is lost without her. "Mum would give me money for the children's things, she'd get me food as well when I was hard up. She was a good mother and a good friend".

Sometimes the loss of the strongest link in the network can have an adverse effect on the cohesion of the network. In one woman's case, her kinship networks were not able to operate effectively in terms of mutual support when suffering bereavement. Although the family offer some support, she described family conflict at the time of her mothers illness and death. "My eldest sister said I was taking liberties when mum was alive, because I kept going round there to eat when I was hard up, so I went less, and this upset Mum. She died unhappy. It caused a lot of conflict amongst us, and there's still some of it there. Mum was strong, when she died the family fell apart".

Kim, Julie and Kathie are single mothers who, like Dianne and Anne, and Deb, were also born and brought up on the estate. Their networks consist of family and local neighbours and local friends. They, like Diane, rely heavily on their local family for support, especially help with the children,

but relationships in their cases are not satisfactory, and may not always provide the kind of support appropriate to their needs or wishes. They are also in disagreement over certain issues. Support, as Radcliffe and Boglan (1988) have suggested, may not be supportive. In circumstances such as these, where opportunities for wider interaction are restricted, a negative impact on health is evident. Their families reportedly do not have time to listen to their problems, and both families took a different view to their daughters on important matters - they wanted the young women to have abortions.

Deb (a single woman without children) lives with her mother, who is the most important person in her life. The similar network, does, in her case too, appear to be a little controlling and perhaps claustrophobic. Her mother came to meet her for lunch at work when I interviewed her. Her only complaint is that "Mum and Dad think I am about 16". The network does not appear to be meeting all of Deb's needs, especially for emotional support. Although she can go to her family when she needs practical help, when she is depressed she takes Prozac for support. The majority of those interviewed in this group were on, or had been on, anti-depressants, and many reported symptoms of poor physical health also. Deb, for example, has a history of poor physical health, particularly for bad period pain, for which she eventually had an operation. The support she received from her mother at this time does not appear to have been wholly appropriate. She and her mother were both afraid of the possibility of cancer, and her mum took it worse. Dense networks, as this case shows, can do little to alleviate the onset of negative life events like health scares, and may even act to re-inforce their impact.

Kim, Julie and Kathie's networks are not wholly restricted to their families . Local friends are an important source of emotional support when things get difficult. When Kim's partner had a fight with a Somalian neighbour she was threatened with eviction by the council. She suffered from panic attacks and depression and lost weight. She was frightened to go out in case someone got in and locked her out: "I would have been in an even worse state if friends had not kept me going". Julie has problems with her children: "They've been thrown out of two nurseries for blowing up TVs by peeing into them, they've been thrown out of doctors surgeries for flooding the toilets and off loads of buses". Local friends 'keep her going' too. Friends here provide emotional support, but, because they are generally similar people to oneself in this group, are not able to help with information or advice to overcome problems. Similarly, because the young women had few outside contacts outside family and local friends, their access to information and additional resources may have been restricted. They did not know where to go for advice on benefits for example, and Kathie

does not appear to have been given any advice or information which could have eased her concern about her abnormal cervical cells. Support from men friends is not likely to be forthcoming. As with the group corresponding to the restricted network model, relationships with men tend to be difficult. Kathie's partner for example, is an alcoholic: "He drinks vodka. I hope he dies and pisses off out of it".

Having children young is a characteristic of most of those interviewed in this group. It may to some extent reflect the lack of opportunity to do anything else, such as a worthwhile job (or indeed any job). A youth worker suggested another reason: "for a lot of the young girls round here, their ambition is to have a baby, as a way of escaping from home". Ironically however, it is not an escape, having a baby does not appear to enhance their lives, and they are still very dependent on the mothers they were trying to escape from. Kathie's experience illustrates her dependence on her mother, who she does not get on with, and on the estate, which is all she knows. Kathie's childhood wasn't happy. Her sister got pregnant at 15, so her mother kept Kathie 'locked up'. Her mum 'beat her up'; when Kathie was pregnant herself, she 'beat up her mum'. Yet now, surprisingly, she spends a lot of time at her mothers over the road and visits every day. Kathie was very unhappy and suffered from depression when she left Canning Town for a year, she found it difficult to cope without her mother and without her familiar neighbourhood. Insular attitudes and lack of opportunities appear to lock people like Kathie into a situation which does little for the quality of their lives, or their health. Kim and Kathie both have panic attacks and suffer from depression, they have both been on Prozac. Kathie is very worried about abnormal cervical cells. She puts this particular health problem down to stress. Though pregnant, Kathie smokes 30/40 a day to help her cope with stress. Many in this group were heavy smokers. Smoking is important to Jennifer for example, it helps her to cope with bereavement, debt, stress and other problems.

Several of the women interviewed in this group felt that having children young had curtailed their social networks, had made them hard up, and affected their health. Their experiences are perceived as affecting their ability to cope, and their health. Sandra had her first child at 19, felt she couldn't cope and became depressed. Sometimes Kim goes to bed and doesn't want to get up. "I've been a mum since I was 16, sometimes, I just want to be myself". Jennifer (48) had her first baby at 18.

> "Life has always been hard, and I've always suffered from depression. I had my family young, so didn't see much of life, I couldn't go out clubbing it and pubbing it, I never went out and about"

The majority of the residents interviewed in the similarity model (as indeed are most residents on

the estate) are very poor. Some of the younger women, as we have seen, receive assistance from their families to help them cope. Middle aged residents don't have this option open to them. Both Jennifer and her partner are unemployed, coping on a low income is difficult, and debt almost inevitable. When she's short of money she goes to some close neighbours, or buys things from a catalogue. "It's terribly hard to manage, I've always been hard up. I always buy things for me second-hand, or what someone else gives me. If I need anything for the house I have to get into debt. It's the only way to get things- out of the catalogue. Its a struggle to pay back but I do it. I rob Peter to pay Paul". She's very kind and helpful to others "My mum was the same, never did no one a bad turn". Jennifer's values of mutual aid would put her into the next, Traditional category, and indeed she strides both. However, unemployment, having children young, moving to the opposite end of the estate, have made her membership groups more limited than the in the Traditional category. She consequently has fewer sources of support.

Now, she often cries herself to sleep "worrying how to cope, who to borrow off now". The ingenuity she employs to cope financially - which includes getting into debt - is having a negative impact on her mental health. The cigarettes she uses to relieve the stress will have a similarly detrimental effect on her physical health. Already she talks with the voice of a woman deepened several tones by decades of heavy smoking. It must be especially hard for someone at Jennifer's stage of life. A traditional expectation is that Grandparents will help financially with the grandchildren. Jennifer's lack of resources make such a role difficult for her.

Networks, as we have seen, can help to compensate for poverty and other problems, but their ability to radically improve things is limited.. Networks cannot be divorced from wider structures and distribution of resources. Yvonne and her husband have five children, and neither are in work. Despite this, they are good managers with their income. In addition, "we get clothes passed on from the family for the kids, and I go without". They also get financial help from Yvonne's Mother, who buys trainers and clothes for the children. Many of the neighbours are friendly and helpful too. Their networks then, are clearly supportive, but their main problems stem from something which their contacts can do nothing to improve- inadequate housing, and lack of play space for the children. Their maisonette is on the top floor of a low rise block. Its location and size are clearly totally unsuitable for a family with 5 young children.

Housing problems affect the health of Yvonne and her family. "My back is not good, from lugging things up and down stairs. I'm on tablets for depression. We are cooped up, four of us sleep in one

room, and wake each other up. The little ones fight on the balcony, it gets you down. We also have a problem with a neighbour who revs up all the time". All of Yvonne's comments on health are linked to housing problems. A disappointment caused her particular anxiety:

> "It knocked me for six when they offered me a place, and then it turned out to be another one upstairs. If only it could have been downstairs I could have been happy. I've been on tablets ever since."

Housing problems here affect health directly, through overcrowding for example, and indirectly - they have little hope for the future. When hopes are disappointed it is easy to see why pessimism and cynicism takesits place.

Although 'life events' including the death of one's parents, affect everyone, they may have a particularly severe impact on the health of people in this model where networks are dense and family based. Her mother's death a year ago affected Anne badly and took its toll on her physical and mental health. She had been very close to her mother, who lived very near, and who gave her a great deal of support. The rest of the family, equally distressed, were not able to give each other the support they needed, and Anne had few other contacts at the time:

> "I lost my mum last year, I dream that she will come back ... I can't talk to my two brothers about her, they just break down. I've had a whole year of stress, kidney and stomach trouble".

Similarly, Jennifer (48) and Dennis (40s) are suffering from bereavement. The most important people in Jennifer's life, the grandson who they were bringing up, and her mother had died comparatively recently. Understandably, Jennifer suffers from stress and depression. Because her network is largely family based, and tight knit, she had no contacts who were not affected themselves.

Not all of those whose networks correspond to the Similar model have poor health, or are unhappy. Sometimes, the network can work very effectively to protect health and enhance the quality of life. Michelle is a 34 year old black East Ender with a husband and four children. She works as a domestic supervisor. Her network provides a good example of a 'proximate extended family', in her case the network is extensive. It has characteristics in common with the 'Traditional network' described later, but the latter has some added on features. Michelle's main contacts are her very large family, all of whom appear to live locally, and her neighbours. Michelle and her husband, her brothers and sisters, and her parents as well as her in-laws- all live within five minutes walk of each other. Other membership groups, such as friends are seen as unnecessary under these circumstances: "I'm not one for friends, my family are my friends...I have contacts at work, but I'm

not one to put myself about" (Michelle).

The family supply most of her needs. When she needs support, be it emotional, financial, or practical support with the children- she goes to one of her sisters. All families have problems however, and the traditional extended family is no exception. In this case, Michelle's good relationship with her sister helps her to cope with family conflicts.

Attitudes and Values

People in this tightly knit inward looking 'Similar' network tend to share similar views. They may be distrustful of outsiders, and attitudes of 'Look after your own' are prevalent. They are not motivated to widen their membership groups and reference groups. They may also feel self contained, and that their networks provide all that they need.

Expressions of racism are found at the more restricted end of this model (among white people especially). Diane's networks for example, seem, at present, to revolve around her own children and her parents. They share similar attitudes towards black people: "Britain isn't fair, you can't say anything about black people" (Diane). "You can't walk the streets at night, not where you get lots of coloured people, its frightening, you think - what are they going to do", (Diane's Mum). Their fears are clearly unrealistic: neither Diane or her mother had been mugged. Their attitudes stem from prejudice, they don't know any black people, and they reported that there were in any case very few black people on this part of the estate.

Expressions of political cynicism (or perhaps realism) is a common characteristic of people in this group. Jennifer and Dennis for example, are both cynical about politics. "They are both arse holes the government..they fiddle the unemployment figures" (Dennis). Michelle too, expresses negative views about the British political system: "It's a waste of time voting, Labour or Conservative, they are all the same, they are there for themselves, they don't live here, they don't know what it is like." Deb (41) sees little hope for a better future for Britain: "you will always have rich or poor, even if you have a labour government, and they are they are all in it for themselves". Neither Jennifer nor Dennis see Britain as fair, they see a country divided by rich and poor, and see little prospect for change. A lack of personal hope for the future co-exists with minimal hopes that things can change for the better in the country as a whole.

Similarly, perceptions of lack of control in their personal lives are reflected in lack of control vis

a vis the system, even to the extent that people see little point in voting. Deb for example feels powerless to effect change: "I'm just a library assistant who left school at 15, those with the power are the ones who can do things". Jennifer and Dennis don't feel that they have control over their lives, nor (unlike those in the Pluralistic and Solidarity networks examined later) do they believe that they themselves can do anything to change things.. Perceptions of lack of control, lack of hope, and fatalism, are, as we saw in chapter 4, linked to negative health outcomes in the literature. People in similar net models, as noted earlier, tend not to have access to a wide range of information. Their attitudes to politics is, to an extent, a reflection of this. Politics are seen in terms of very localised issues, and some in this group don't distinguish between issues and services which are the responsibility of the Government and those which are the Council's.

These examples illustrate how attributes which the literature has shown to be health damaging, and which are linked to lower social class and poverty - particularly lack of control and fatalism - interact. They interact in a social network consisting of people largely like oneself - generally family - and a situation where people see little need to broaden their positive reference groups and to identify and mix with others. Fatalism, relating to one's own life and the way society works in general, and political cynicism are associated with a disinclination to join organisations and groups to try to change things. Parochial attitudes however, are very much part of the picture too.

It is not only the structure and characteristics of one's social networks which can influence attitudes of course. Being at the sharp end of a situation where resources ae scarce are clearly important influences too. Housing problems for example affect Yvonne's attitudes to politics and play a part in structuring her reference groups also: "Newham isn't fair, keeping us here upstairs, when a lady can come over from Nigeria and get a 4 bedroom property. And why should disabled children get more resources in the school than our kids?" She won't vote: "The Labour Government round here, [that is the council] they never helped us". (Yvonne) A situation where people feel in competition with others clearly creates divisions. Kim, Kathie, and Julie express resentment that refugees get more help than them, and that some people get more income support than they do. When jobs are few, when there aren't enough homes for large families, or where pensions or benefits are totally inadequate for needs, positive reference groups are narrowed and negative ones widened. Attitudes of looking after your own grow from a situation of scarcity; a widening of reference groups involves seeing a wider array of groups as like oneself. Solidarity does to some extent appear incompatible with a situation of scarce resources.

However, people's lives and attitudes do change in ways unconnected directly with material

resources. Anne and Maisie's networks are both developing from a similar model towards more open structures.

Anne is a 40 year old single parent with three children. Her mother's death meant that she lost her main source of friendship and support. Anne's networks are developing outwards to include more membership groups and positive reference groups. Things have changed for her since she joined the Tenants Association, but she initially "only joined to help her friend, not from a burning desire to change things... "it's only since Christmas that I've changed, I get out more, and go out with a group of friends for nights out". Her friend - who is a highly active woman - has probably influenced Anne's opinions. Anne has definite political opinions and knows what she would like to see changed for vulnerable age groups:

> "Youngsters, from the day they leave school they've got worries, no jobs. Its not fair, the Government ought to look at people, and see what they are doing to them, they should give back something to the youngsters, and the elderly, they have robbed them."

For those who may feel restricted by their 'Similar' networks, policy interventions as well as self help groups like tenants organisations can be important for extending their membership groups and positive reference groups. Maisie is a 25 year old black East Ender and single parent. Her networks are extensive and localised. She 'knows everyone', but perhaps this is not enough for her, especially as she considers that her children are holding her back from enjoying herself. She comes to Newpin every day. "My kids can play with the others, and can learn. Its a break from being indoors, and on Friday we cook together. I've made friends here, now I can support people, and I don't get as bored as I did". Her new friends don't know her old friends, Newpin has opened up her networks, in terms of density - the structure is now less dense - but also in terms of mixing with dissimilar people too.

> "I can get on with people here in Newpin who are much older than me. They can cope, they've experienced more, I like them better than people of my own age. I go to Bingo too, and enjoy the company of older people there."

These changed networks are likely to be beneficial in another sense - they will open up avenues of information and other resources. Being prepared to mix with dissimilar people here clearly helps Maisie to cope, and to learn. Maisie feels in control of her life and has good health except when a bad relationship precipitated depression. Newpin helped her get over it.

Life Experiences and Attitudes to Health

So far I have looked at the components of residents' networks, the people in the network, the

network structure, the benefits the networks provide, and considered how these interrelate with both values and attitudes and individual's reported health status. Before going on to examine the next network model - the Traditional network - it is useful to consider here the views of residents in the Restricted and Similar groups on what they themselves think affects health.

Interviewees were asked to talk about when times were good and times when life was not so good, and about the sort of things which they believed influence our health. Some issues - such as bereavement - were mentioned by people in all models. Other issues and experiences however, were more salient in some models than others. Not many of those whose networks corresponded to the Restricted model had much to say about times when life had been good. Poverty, having children young, difficult relationships with partners, together made for more of the bad times, and a life characterised by struggle. Some interviewees however, had moved on from this phase in their lives, and were now able to contrast the lives they were now leading favourably with their more restricted, earlier lives. A minority in the Similar model mentioned their youth as a relatively happy time, or the time when their children were little, times when they gave and received love. Bereavement (as in all models) was described as as a particularly sad life event. The density of their networks, and the similarity of the people in their networks, however, as we saw earlier, may well have acted to compound their unhappiness. Other family members were too involved themselves to be supportive.

Those who had experienced bereavement saw clear links between these events and their own deteriorating physical and mental health. When Deanna's mother died for example, her health suffered, and she had little faith in the efficacy of medical treatment. "My health is worse than average. When mum died I was depressed, and my body packed up, I couldn't stop bleeding, then my body shut down. I developed a stomach ulcer. I'm no good at tablets, I don't like taking them". Not being able to get out when the children were small was mentioned by one in connection with depression. Feeling held back by children was seen by some as frustrating and stress making. Some, who had had children young simply expressed it as "never having a chance to enjoy life".

Residents identified various aspects of material deprivation which they connected to ill health. Not surprisingly, worrying about making ends meet was seen by many as detrimental for health, mental health especially, but physical health also. "Always having a hard life" was one way this was expressed. Experiencing poverty as a child was also mentioned as damaging to adult health by one respondent. Several made connections between *stress* and ill health, and mentioned stress in relation to money (as well as relationships with men, or problems with children.) Housing was

seen as important by those who were living in, or had experience of,inadequate housing. Children waking each other up in the night in overcrowded conditions disturbed parents' sleep patterns and health. The isolation which can go with living in a tower block was also linked by one respondent to depression and heart problems. Tiredness was seen as affecting health. Michelle's health for example, is generally good, but she suffered from depression when she had her first baby (at 19), and pleurisy when she was working and the children were younger. She puts this down to over tiredness, "We were trying to make ends meet" .

Some of those in the Similar network group thought that food was important to health, but that it was difficult to afford. Those in the restricted networks group tended not to mention food (their problems tended to be so pressing that mundane matters, including diet, did not come to the fore), but one who did had a somewhat ambivalent relationship to it: "I get by on Income Support, because my kids aren't big eaters anyway. They are fussy eaters, so I don't have to cook meat". Most of those interviewed in both groups smoked, and considered smoking as an essential coping mechanism. For example "I'd be a lot worse without it" No one made direct links between smoking and ill health. For example: "I've developed asthma. Yes, I do smoke, but I've smoked since I was 16, so it can't be that". A combination of fatalistic attitudes plus lack of information - which we saw was a feature of the Similar and Restricted network structures - may be playing a role here.

People are perceived as affecting health in a number of ways. Stories of relationships were constantly interwoven with accounts of their own health, and of attitudes to health generally. For example: "if they are giving you a bad time, then that's depressing. If you've got somebody good in your life, you've got everything to live for". Or, as one woman, whose networks had once been very restricted but were now very different, put it "a bad man can make life hell". A woman in the Similar group who reported that she did not feel in control of her life, related control to relationships with men. She also linked good health with success with boyfriends. "When I finished with one boyfriend, I didn't go out for 10 yrs, I was depressed". As noted earlier, when people making up the network are restricted, or those in the network are similar to oneself, then the quality of the individual relationships in the network are especially important for health and well being. Network members are not only very dependent on each other, but restricted size and similarity limits the potential of the health giving benefits available from the network.

Getting on with people, especially partners, was seen as important for health. Happy and contented children was seen by one woman as important for the health of the parents: "If the children are

happy, contented and occupied, if there are good facilities for the children, then the parents are happy and healthy too" (Rose). Generally, people saw that being able to talk to others about problems was good for health, and amongst the similar group, having family support when things go wrong was highlighted.

Some of this confirms the analysis so far, and some does not. No-one for example, not unsurprisingly, linked fatalistic attitudes to poor health, or attitudes to 'outsiders'. However, perceptions of hopes being dashed - in connection with the promise of new housing, was considered by one woman to have had a very detrimental effect on her health. One of those whose network was developing from a similar to a much more open network, was extending her positive reference groups and spoke of people unlike herself in connection with health. She was concerned about the effects of unemployment on the health of the young: "They will be old by the time they are thirty. No jobs is bound to effect their health" (Anne) .

THE TRADITIONAL NETWORK

This network model is made up of a mid range number of membership groups, more than the Similar model, fewer than the Pluralistic and Network of Solidarity models. The groups will include those made up of family, neighbours, ex workmates, old school friends, and friends from social clubs and sports clubs. The structure is tight knit, that is, most friends know each other and know the family. The network consists largely of local members, though the kinship element can operate as a 'dispersed extended family' in a few cases.[8] The individual will have spent most, if not all of their lives in the immediate area. The model has features in common with the previous, 'Similar network' group, but the Traditional model has some additional features. Experience of working locally in the past, membership of social clubs, had given individuals something of a collectivist outlook on life. Their experiences and build up of resources -social capital- helps them to cope with life and health problems.

The last chapter described aspects of the 'traditional community' on the Keir Hardie Estate. In particular, it described the strong norm of mutual aid in the past, and the strong community spirit which persists into the present. The networks which correspond to the traditional community are the Traditional networks. The members of an individual's networks have a great deal in common, they will probably have grown up in the locality, worked together in the same factories, gone and continue to go to the same clubs, and will have married locals. They are strongly attached to the

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8 The term 'dispersed extended family' is used by Peter Willmott (1986)

people of the estate and to the area itself. The model is more likely to apply to the older generation than the younger. Friendships are long lasting for those in this model. Mavis, for example, used to be a member of the Docklands settlement when she was young. Now she goes to the pensioners club at the Cundy centre and and still goes on the Mayflower outings. She made most of her friends there, and at Knights soap factory and where she used to work. They had a social club there too. Ellen also talked about the continuity of friendships: "I've known some of the people who come here [the Pensioners club]since we were children, we was all born near here".

Although most of those interviewed whose networks correspond to the Traditional model were elderly, there are younger people in this category too, yet we can expect their numbers to be dwindling. Lisa (33) is a jolly, happy and friendly woman who lives with her husband and son in a low rise block. Her husband is employed, he makes coat hangers. Her Networks are locally based, she knows lots of people, some of whom she met when she worked in Tescos, where she was a member of the union. She made lots of friends in the local social club:

> "We used to have a social club in the high rise [where she lived before she moved to her current block], we took the children along, but its shut now, they ran out of money. I made loads of friends there, and it was cheap. It was shut 9 or 10 years ago, lots of people round here used it, and still talk about it."

Old friends continue to support each other. Mavis (80) doesn't have children, and, like the childless elderly in general, the local arena is very important for her. She gives a great deal of support to her elderly friends and neighbours: "Yesterday I went to Rathbone market, I got some boiled bacon for a friend, then I visited some friends who can't get out much". I noted in the last chapter that the accounts of mutual aid before the war often involved the exchange of food. Food cropped up several times in conversations about supportive friendship networks in the present. Ellen described what she did yesterday: "I opened up the club, cleaned up, talked to the people working here, then a friend came over for a chat and brought me two rolls". Pam has a close friend of 35 years standing, who now live in Dagenham. They take turns to have each other over for lunch on Sundays. Audrey has kept in touch with many of the friends she and her late husband knew when they were working in the dock or factories. She offered a nice definition of friendship: "When I make a bread pudding I make one for John too. People think we are an item, but we're not, its just friendship".

People in this group can usually rely on a good level of support of various kinds when they need it. Pam for example is a widow in her 70s. She has tight knit networks of family and local friends.

For support in times of illness, or emergencies, she goes to her daughter in law's mother, who lives locally (her son married a local girl), or to a local friend. For emotional support she has her old friend in Dagenham, and for particular problems can ask the local councillor, who is also a friend. They all know each other. Her friends were very supportive when her husband died, though the support they gave may not have been always appropriate: "They never left me when my husband died, it was good of them, but sometimes I could have wished them to buggery, I wanted to be on my own." Ellen (68) was a school cleaner for 23 years, and her husband worked in the docks She appreciates the support she receives from her family - her daughter took three weeks off work to look after her when she came out of hospital for example - and they pay for her to have treats and outings. But sometimes, she says, it can be more than she needs: "The year before last I had to have an X ray and a blood test. All the family converged on the hospital, all you could see was cars. It was hilarious".

Families, though a prime source of support, it seems can be a mixed blessing for the elderly, and the women interviewed were able to cope with life successfully because they had other membership groups to balance their lives. Audrey (73) is also a widow. Although her children no longer live locally, she has a great deal of contact with them. They phone her everyday, and she visits them each weekend. Her children and her local friends know each other. If she is ill, she can ask her daughter or local friends for help. When her husband died, her daughter stayed with her for two weeks. Sometimes, however, Audrey's family give her inappropriate support. She applied to move into a bungalow when her husband was ill with heart problems: "I waited 10 yrs for this bungalow, and moved in just before he died in hospital, he never saw it. That's why I don't like it, there are no memories here. My girls and son slung everything out, they threw out everything down to the last teaspoon. They said I should start anew".

Memories are, of course, very important for the elderly. Fortunately, Audrey is able to re-live them at the Pensioners club. Her final remark emphasised the importance to her of the activities she was involved in: "If I couldn't get out I'd be very unhappy".

This group are highly active socially. Pam and Audrey also 'help out' for the Labour Party, and Mavis, though 80, still goes to Labour party meetings sometimes: "We're all Labour round here" Pam, Audrey and Ellen are all involved in organising pensioners clubs. Pam explains her involvement in terms of having always been active, she used to run a keep fit session, for example, for children and mothers. And as we saw earlier, today's active pensioners were active in youth clubs and work based social clubs in their youth. Audrey too helps out at the Cundy club and

explained that she gets just as much out of involvement as she gives:

> "I just enjoy being with people and doing something, and making sure that other people get something to do. When I did the home helps I saw so many who never went out or did anything, and I worried that I would be like that."

Ellen is a regular volunteer at the Cundy Centre. She appears to enjoy the routine and regularity of it, as well as the companionship, and comes every day. Although she is very close to her daughters, and sees a lot of them, her involvement in the Cundy centre has caused family friction:

> "All my daughters resent my involvement in the club, particularly because I've been ill. They say we phone you, we come over to see you, but you're not in, you're always at the club. They think that I should lead my own life but I get enjoyment from being here. We meet and talk about when we was kids, and what we used to get up to."

When families are controlling like this, it is clear that being active in the club, and the companionship she derives from it is important for Ellen's quality of life. It also helps to take her mind off her health problems which I suspect are quite serious. Residents in the 'Similar' group, as we saw earlier, do not have this kind of outlet.

The traditional network on Keir Hardie correspond to the characteristics which we might associate with the old East Enders. They are the 'responsible working class', with values which emphasise coping, mutual aid and getting on with life. Coping includes for some, a denial of the need for emotional support, they prefer to 'get on with it'. Like many of her generation, Mavis (80) is a coper: "Emotional support? I don't ask, I get by on my own". Audrey doesn't feel that she needs emotional support "I just put up with it".

One of the traditional values is a desire to avoid getting into debt. Lisa, for example, takes pride managing on her income. She disapproves of people like her sister who "blow all their money on a cruise then have nothing for months". When people lay great stress on the value of coping financially then get into debt through no fault of their own, their health can be adversely affected. An unscrupulous loan company has landed Mavis (80) with a debt which she has repaid over and over. The stress and the shame of it is making her ill. "I got into debt when Frank died 10 yrs ago, I got some clothes from a catalogue, I never told my family. But the company got it wrong. I paid it, yet they went on demanding more and more money. The trouble started when a new firm took over. I'm still paying them". Mavis felt totally out of control here. Her networks are fine for most purposes, but unable to give her the kind of information she needs to deal with sharks. She does not, in any case, like telling people about it, and feels ashamed.

Attitudes

Despite the mutual aid, the sociability, the strong community spirit, this is still something of an inward looking network, though less so than the Similarity network. Solidarity is a 'conditional solidarity'. Residents positive reference groups, in several cases, are still, to an extent, limited to people like themselves. They do not think that Britain is fair: "The longer you live the worse you get treated. I stand behind foreigners in the Post Office and they are getting better pensions than me," (Pam). "Our children are born and bred in this country yet they can't get a council place. But the foreigners come in and get all the new council houses," (Ellen). They would all like to see more done for children - in terms of educational opportunities - and pensioners: "You never hear of big rises for pensioners, yet we work hard all of our lives" (Audrey). Mavis, however, is the exception here, and has wider reference groups: "I'm a born mixer, young and old, black and white". Her attitudes are found more commonly in the Solidarity model described later, than in the traditional one.

A certain amount of political cynicism is evident amongst some of the pensioners, though its less strong than in the similarity group, and, in these cases, is based upon their interpretation of current trends, rather than total despair. Ellen's thoughts for the future are pessimistic: "Although I belong to the Labour Party I don't suppose I'll vote, I don't suppose they'll do much better". Audrey thinks the [Conservative] Government want to bring back the old class distinctions, the distinctions between rich and poor, and she wouldn't like that to happen. "It's not a future I would want to see".

Life experiences and attitudes to health

They all had good times to look back on, and continued to enjoy life now. Older people talked about the good times during their childhood and youth, when they had a choice of jobs in the factories in Silvertown, and about the rest of their working lives when they had lots of contact with their workmates outside work. Although a young woman, Lisa's comments were typical of many in this group: "Life has been good all the time. Life is what you make it, and what kind of people you have around you,"(Lisa).

Some particularly enjoyed the war years. Audrey worked as a NAAFI cook during the war. "It was the best three years of my life. I was young, nothing worried me. You was all together, there was no Mum to tell you you had to be in at 10. You met people from other parts of the country where you'd never been. In those days you didn't normally travel around. I only had one day out a year,

at Southend, when I was a child" (Audrey). What is interesting in this account is the changed network structure which went with the upheaval of the war years. Meeting different groups of people gave Audrey a new slant on life. It was noted earlier that health inequalities narrowed during the war years. Although the reduction of material inequalities made a major contribution, the experiences described by people like Audrey may have had a role to play also. For those engaged in active service however, or who lost families and friends during the Blitz, wartime memories, as we saw earlier, were less rosy.

Bereavement, as expected, was mentioned as a sad time for many, but having friends to get you through it was also highlighted, as well as being strong enough to cope. Traditional Canning Towners don't wear their hearts on their sleeves. The value of coping with life was reflected in attitudes to health. Interviewees, as we saw earlier, emphasise the importance to health for example of managing on your income, and not getting into debt. Lisa for example speaks critically of her sister, who will get into debt to go on an expensive holiday, and then worry and make herself ill to pay for it. "I prefer to save up, then only when I could afford it I would go. That way there is no stress" (Lisa).

Being strong willed and coping with life and health, are seen as highly important. To admit that one did not feel in control of one's life would be anathema to these traditional Canning Towners: "Life affects health if you let it get on top of you. It depends on how strong a person you are. I get on with it, my Mum always copes too", (Lisa). "Getting on with it" and "not making a fuss" was typical of attitudes to health of all of this group, even where - in the case of the elderly people, there were quite serious health problems. Pam doesn't like to make a fuss, although she has thyroid problems, and has had operations for cataracts and breast cancer:

> "My [bad] health has never prevented me from doing anything, only when I broke my wrist. I don't make a habit of going to the doctors. You can get to be a hypochondriac. I don't think its right to waste the doctor's time if you can get the tablets to do it yourself. I had breast cancer when I was 47; it didn't worry me" (Pam)

Not admitting to worrying about health, or giving in to it, is seen as a virtue: "I've always been chesty, I've got a smokers cough. I don't take no notice though, I've got my pump. I don't bother with a walking stick either" (Audrey).

Despite the desire to remain in control over health issues, not give in to it, attitudes to health include [as they do in the Similar networks]a strong streak of fatalism, especially where smoking is concerned: "Cigarettes, I don't let them bother me. What's got to be has got to be. I still smoke, its

no good worrying about it" (Ellen). Smoking is not such a key coping mechanism as it is for people in the other networks considered so far. People with traditional networks have many outlets, friendships are important to them, and they are generally more content with life. Smoking is just a habit, something you do, like 'helping out' the Labour Party. Keeping active is seen as a means of coping with ill health, as well as preventing it. 'Keeping active' is also proof that one is not making a fuss, that one is coping, that one is in control. Ellen is a heavy smoker. Her health is now very poor: "Its going downhill, I've lost a lot of weight and I get very tired. I'm waiting for the results of tests. Being active though helps me cope with it...I don't let it bother me", (Ellen).

Other behaviours are seen as detrimental or beneficial to health. There was strong disapproval, of people (foreigners) spitting in the street. People with traditional networks have positive attitudes towards "good wholesome food" and to cooking. The older ones suspect that young people don't eat wholesome food now. Cooking meals for friends, as we saw earlier, was also part of the normal way of life for this group. Good food is linked to good heath by many of the traditional residents. As Mavis put it "Health? I can't grumble, I always try to cook proper dinners." Food is also talked about in terms of social activities and support. In contrast, food did not tend to crop up in conversations with those in the Restricted and Similar models.

THE PLURALISTIC NETWORK

The Pluralistic network is an open network. It will consist of a relatively large number of membership groups. The size of the groups will vary. The network is likely to include dissimilar people, in terms of age, ethnicity, interests, employment status or occupation, and place of residence.

Generally the networks will be loose knit, but in some cases - such as a person involved in voluntary organisations which are all interconnected-will not . Friends are likely to be loosely connected, and friends and family are less likely to know each other than in the other models. The principal example of an individual whose networks correspond to this model is the person active in a range of voluntary organisations, and who may be in contact with a range of people, some of whom may be different from themselves. The individual themselves may be different in some way from their neighbours, not born locally perhaps, or had worked outside the locality.

Bessie is 66, retired, and lives with her husband in one of the tower blocks near the A13. Although Bessie has lived on the estate for most of her life, her job (in personnel), unusually, was not local.

She is now chair of the Tenants Association for her block, and sits on various housing committees. "I first got involved years ago, through the Ronan point campaign. They were just going to rebuild it up the side, but we wanted it pulled down". Belinda, a single parent, moved to the Estate from Wales six years ago. She is not in paid work, but is highly active in a range of local organisations. She is chair of her Tenants Association, secretary of her Community Forum, and chair of the SRB partnership board.

These active women gain a great deal from participating - i n feelings of control, self esteem, a sense of achievement and in doing something for others. Although much of their time is taken up with meetings, Bessie and Belinda don't complain, both are motivated by a desire to achieve change. Their altruism is mixed with a little self interest, Bessie for example, finds her involvement with the tenants association rewarding: "You feel as if you've achieved something at the end of the day, and there's the possibility of improving other people's environment." Similarly, Belinda gains a sense of achievement when changes happen.: "If you have a valid point, the council will listen to you and react".

Intense local involvement also brings with it the opportunity for Belinda to broaden her networks outside of the estate, an aspect which she particularly enjoys. Both women say that they feel in control of their lives, and relate this control to being actively involved in trying to change things for the better.

Although many of the people involved in various tenants associations know each other, "you tend to see the same faces at meetings". The structure of their networks is otherwise generally loose. Bessie's daughter and Belinda's family - none of whom live in London - don't know the committee people. The structure of their networks are such that they have access to information and other resources, but may not always have access to practical or emotional support of the kind available to those with Similar or Traditional networks. For support Bessie relies on her husband, and consults the doctor if she is ill. She does not feel she could call on neighbours for help, "The neighbours haven't been here long enough". The tenants in her tower block are predominantly young people, (Bessie's opinion of those in her block was described in the last chapter) and she prefers to keep her distance from "young people who make a nuisance of themselves". Despite being so active, Betty nevertheless sometimes feels isolated: "especially living here. I'm not sure whether isolation is my own choice or whether I've had it forced upon me. I don't have any immediate family within easy reach and its [the Tower Block] not a neighbourly area". Bessie described her health as "it could be better". Belinda also feels isolated sometimes "Round here its

very family orientated, they all have cousins and so on locally".

Belinda is a giver. "I don't find it easy to take" Although she clearly does a great deal for the community, she does not feel that she can ask for support for herself. 'Loose' ties, in her case, are not 'strong' ties:

> "If I'm ill, I wouldn't ask anyone, I'm here to suffer. I had bronchitis in April, I just had to get on with it. I wouldn't ask anyone to look after the kids. Mum thinks I've been on my own too long, but its part of the price you pay for being independent [divorced] I don't rely on anyone; no-one can let me down...However, when I've had a bad week, when I've had a lot of pressure connected with meetings, and the children have been playing up, its then that I feel isolated. I wish someone would knock on the door and say I'll have your kids for an hour. I miss my family being around to do that."

It is surprising that neighbours are not more supportive to Belinda, but, as noted in the last chapter, estate residents do not take kindly to outsiders, especially if they are different, and heavy involvement in organisations is certainly different. Attitudes of 'looking after your own' here, do not, in any case, extend to the Welsh.

Yet being away from her parents and the potential for support does have its compensations: " I do get on better with my parents than when I lived in Wales: Mum thought she had to live my life for me" . In contrast with many in the Similar model, who tend to be family orientated, and some of those in the Restricted models who were coping with a difficult partner, she now feels in control of her life, and contrasts her present experiences with the time she was married, when :"I didn't have the courage to stand up to him . He drank and hit me. I'm in control now". She also clearly gains a sense of control from her voluntary activities. An arena which causes difficulties for her is the financial. It is ironic that Belinda, who does so much for the community, and her children have to survive on income support:

> "I scrape along but I'm OK, I could be down to my last pound but I manage. I may do without myself, including doing without a meal. It would be a luxury to have a magazine. Its hard and getting harder to meet the demands the kids put on you. They should let us earn £20-25 per week when on income support before they take it off us."

Belinda's experience of poverty is important to note here. In this respect she is no different to many of those single parents in the Restricted and Similar groups: "It is such a worry, not having enough money builds up on you and you take it out on the kids" (Belinda). Yet her life, in other ways, is very different. She responds to poverty differently, by trying to do something about it, for

the common good.

There are some similarities between these networks largely based on participation in organisations, and networks largely based on work, though in terms of structure, the networks of those active in organisations may be more scattered. Tessa (30) has an interesting job working for a voluntary organisation, and has met lots of people through work. Most of her leisure activities involve work friends, she has not kept up with school friends. Her networks are loose: work friends do not know her neighbours, or her family. She contrasted her situation with the parochialism of others: "I've got a few acquaintances who have never been out of this area. I was the same until I started working for the network. If I'd stayed in the same rut I would probably have gone mad". Like Bessie and Belinda, Tessa is not able to access support from her family, but not, in her case, because of physical distance. She gives a great deal of support to her elderly parents, with whom she lives, but asks for little in return. "I can't think of anyone who could lend me money, they are all skint. For emotional support, I go to friends, not my family, they are all stiff upper lip types". Tessa feels that she has little in common with her family and neighbours now. The benefits which can be derived from participation in voluntary organisations are similar to those associated with work. Like Bessie and Belinda, Tessa feels in control of her life, but, in her case "not when I'm too busy to solve problems". Tessa has had a number of health problems in the past, not unconnected to a problematic childhood. Her health has improved over the last two years or so, since she's been working, making new friends, as well as acquiring more information on how to protect her health. "Now I take care of my diet, and exercise, and don't push myself so hard".

Gaining in confidence and self esteem is part of the explanation for Tessa's improved health status: "I've changed a lot in the last five years - its having to deal with people, I've learnt all the social skills I didn't learn at school". The contacts she has made at work have also given her information and access to resources (such as knowing how to make demands on the health services) which were not open to Tessa and her family before.

Attitudes

The attitudes of the people in the Pluralistic group are quite different from those considered so far. A wide range of membership groups co-exists with a relatively positive outlook on life. Unlike those in the Restricted and Similarity model, fatalism and despair are not characteristics of people whose networks correspond to this model. They have an idea of what improvements they would like to see in the neighbourhood and in the country as a whole, they believe progress is possible and see a role for themselves in the process.

Belinda thinks that Britain is changing for the better but that it's a slow process. She sees a small role for herself: "If I get involved, then at least I can say that I have tried" . In the future she'd like to see better health services, education and training opportunities in the country as a whole. For herself, she'd like "just enough money to get through each week". For the neighbourhood she'd like "more of the community spirit brought back like the old people say." Bessie would like to see a better future for her grandchildren, and believes that she has a role to play, in working towards it.

As well as differences in attitudes from the Similar and Restricted groups, differences are evident from the Traditional group. The Pluralistic group, although like the Traditional are committed to the area, are less committed in a sense to the people. Their own sense of personal identity with the community is weaker. They see their fellow residents with a clear, less rosy, and sometimes critical eye. Bessie's positive reference groups, as we saw earlier, do not include the young people in her block. Belinda is not an East Ender, swearing and aggressive behaviour on the part of some local mothers towards their children makes her disinclined to want to be. She is also critical of residents abusive behaviour in general: "The council are afraid of talking to my tenants because they are afraid of being sworn at and threatened. The tenants will have to be re-educated". It was suggested earlier that lack of neighbourly support for Belinda was connected to her status as an outsider. There may be a two way process involved here for Bessie and Belinda however. Supportive relationships need a degree of recognition of shared interests on both sides.

All three cases in this group have a wider view of social stratification than some of those indicated so far. Belinda sees society divided into those who have power, and those who do not while for Bessie society is divided principally along the lines of rich and poor. "You've always had your rich, your very rich, your middle class and your poor and downtrodden. The East End is looked down on, they think we are all ignorant and illiterate. People shouldn't be classed as second class, they can't help where they live.. Me? I'm difficult to place" . Tessa dislikes divisions- "everywhere you see divisions of race, creed and money, and divisions between those who condone, and those who act".

Despite this general view, Bessie's positive reference groups are limited to certain sections of the poor: "Britain is not fair, not to pensioners. Yet they give all this help to asylum seekers and refugees, and drain it off the money that people have paid in through taxes. Our combined pension doesn't keep us, we've had to rely on our dwindling amount of savings. Because we've worked all our lives, we should be able to have little luxuries now, and go on holidays, but we can't". Again,

wider solidarity does, to some extent, require a better distribution of resources to flourish.

In describing the sort of Britain she'd like to see in the future, Tessa's attitudes and reference groups are better located in the solidarity model described in the next section: "I'd like to see people getting together and learning about each other; I'd like everyone to be the same shade of brown, more Government input on health and education, and more festivals, to integrate people." She does not however, as we saw earlier, share the commitment to people living on the estate evident in the Similarity, Traditional, and, to some extent, the Solidarity model.

Life experiences and attitudes to health

Like those in the Traditional model, coping and character were seen as important ingredients of good health. Although there were some similarities in perceptions of how you cope, there were also differences. Coping, for both, is an active process, keeping active is seen as protective to health in the Pluralistic model, and for keeping your mind off health and other problems in the Traditional. However, coping with health and illness - as opposed to life in general - for the Pluralistic group is more of an active process, there is none of the passivity or fatalism evident in attitudes towards health held by the Traditional group. Just as they believe that they have some control over their environment, and can take an active part in achieving change, so they recognise that they have a role to play in protecting their health. Belinda for example: "health, its all down to your character, and how you cope. Some can't cope, they drink or smoke." Diet and exercise, as well as looking after yourself, not pushing yourself too much, were seen as important contributory factors to health by those in this group. They are aware of health promotion and act on it. Indications that people in the Restricted, Similarity and Traditional models don't take note of health promotion advice, suggests that take up is connected to the composition of residents social networks. A wide range of membership groups providing a wide range of access to information is clearly important.

Additional factors perceived as affecting health included bereavement. Bessie was the only resident in this group to have had this expereience. She believed that it could have physical effects: " Something can set off the arthritis, like when my mother died, and I was a bit low". Belinda and Tessa, like those in the groups already considered, mentioned that people can affect health. Belinda for example, once led a rather restricted life when married to a difficult man: "its how they treat you, whether positively or negatively which is important for your health.. My friends are like minded and supportive". Tessa believed that people could cause stress to others and therefore have an adverse affect on health. She had her own parents in mind. They are uncommunicative: "they

won't ask, but complain if things are not done".

This group were critical of local health services: "You have to wait a week for an appointment, by which time you could have cured yourself or died" (Bessie). "Its difficult to recruit GPs into this area. One committed suicide in his office, and they haven't replaced him. There are long lists, and long waiting times to get an appointment. It took me a month to get an appointment to talk about mum" (Tessa). However, they do use the health services, and make demands on them. Not for them the " I don't want to bother the doctor" approach of the Traditional group.

Perhaps the most significant comment on health came from Tessa, who believed that 'staying in a rut' affected your health. What differentiates this group from those considered previously, is that they do not stay in one.

NETWORK OF SOLIDARITY

Networks of solidarity consist of a wide range of membership groups, made up of both similar and dissimilar people. The Network of solidarity is a cumulative model which has many of the positive features (for health) of the other models. Network structure is both dense and loose, and generally corresponds to the Hirsch model, it consists of several dense clusters with loose density overall.[9] Networks share many of the characteristics of both the Traditional and the Pluralistic model, that is, strong local contacts of family and or neighbours on the one hand, plus participation in formal and informal organisations on the other. People whose networks correspond to this model also have - like those in the Pluralistic model - a vision of hope for the future. There is an additional, and significant, feature which characterises this model. People have a wide range of reference groups, they recognise interests in common with a diverse range of groups. Though this feature is not totally restricted to the solidarity model, it is found most frequently here.

An example is the individual with strong local ties who is also involved in initiatives, self help groups or organisations such as tenants groups or churches. Participation widens their networks both geographically and socially. There are similarities with the Roseto model, where a high rate of participation was linked to low rates of heart disease, (Wolf and Bruhn,1993). But Roseto was a homogenous society, they were all Italian Catholics. The networks of solidarity in East London encompass dissimilar as well as similar people, and open outwards. Attitudes, like those in the

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9 See chapter 4.

Pluralistic group are less likely to share the parochial element common to the other networks.

The residents interviewed in this group, as well as having strong ties of family and friends, were involved in a wide range of organisations. Chris (53) for example is a school governor and involved in the church. She became involved at first to fill the time when her husband died; now its a pleasure, she enjoys it. She is also training to be a social services lay inspector of children's homes: the work will take her all over London. Already her networks are opening up : "I went to a meeting the other day where I met entirely different people from myself. I was the only one there with a cockney accent". This new group of contacts do not know Chris's family and local friends. Erin is active in the Tenants Associaton, and similarly, her Tenants Association friends don't know her family; "a few of us started it 2 years ago, to organise trips and dances and to raise money". She is also active in her church. Henry (78) was born locally, has many local friends and long term supportive neighbours and is very active locally. He has been involved in sports, youth and social clubs since his youth and is a member of the Conservative club. He's been involved in the St Luke's Project for three years - since the beginning - and is on the management committee. Agnes (60) is a nun whose order are committed to helping and working with the poor. She lives on the estate and works to encourage self help projects. She has contacts all over the world.

Val, (50) like all of those mentioned so far (with the exception of Agnes) was born and bred in South Canning Town. Neither she nor her husband are earning She combines a close knit local extended family, with a diverse range of contacts met through her involvement in a range of organisations. Val has run her local tenants association for ten years, and helps to run a number of groups involving local residents including a mothers and toddlers, a bingo club, and an after school reading group. She is chair of the Custom House and Canning Town Community Renewal project, and works hard to improve the lives and living conditions of people in the area. Her activities have broadened her networks, and brought her into contact with a range of local and non local organisations.

The rich qualities of 'Networks of Solidarity' are health promoting. People gain support from friends and family, and have access to additional forms of support and information through their additional contacts. Through participation, they gain in esteem, self worth, feelings of control, as well as a sense of satisfaction and achievement.

Henry for example has local and non local friends who he can rely on for support, and neighbours

will help if he is ill. He consulted the CAB recently for advice on a legal matter. Henry is generally in good health, which he puts down to keeping active. He does a little part time job- delivering things "to keep my brain active." Chris can ask her family for support when she is ill, can go to friends or family for financial support, and friends for emotional support. Her comments illustrate the importance to her of a wide range of membership groups, not only for her quality of life, but for coping with 'life events'. When her husband died:

> "the family were a bit too close, we were all hurt. The people I work with are my friends, as well as my colleagues, work was my safety valve, a life line at that time. They treat you normally, you can have a laugh and a joke with them. We give support to each other at work, we talk over our problems, although we are all different ages."

People like Chris seem to be able to withstand a certain amount of stressful life events, not in the way of those in the Traditional model by 'getting on with it,' but because they have built up social capital, they have a wide range of support and advice to rely on, as well as outlets for their energies.

Chris also mentioned the importance to her of both strong ties: "I get on best with people I have known for years, you haven't got to clear up when they come round", and loose ties: "I never feel isolated. If I feel fed up I'll just take myself off down to the market. ...you stop worrying about your own problems, because everyone has a tale to tell". Chris has always been in excellent health.

Erin is married with children. Her husband works for Tate and Lyle, one of the few remaining dockside firms. Erin's large proximate extended family is very supportive, as are her in-laws. She married a local boy, and was only 19 when she had here first baby. She recognises that support is very important for families with children- she can take hers round to her mother's or her mother in law's and leave them there. She would like to see a support network set up for parents on the estate, for people who don't have her advantages. Her sisters and family will provide emotional and financial support. She gives support too: "I'm the agony aunt, if there's a family problem I try to sort it out". She spoke about the benefits of being involved in the Tenants Association:

> "My life has changed since I became active. I'm in the community now, I've got to know more people, I mix with more people, and have gained in confidence. I feel in control. If I had spoken to you two years ago I probably would not have said much".

Erin's case is particularly interesting because it illustrates how people's quality of life can change. Her childhood was not happy. Like some of those considered in the similar model, she had a baby young to escape it. Despite feeling that she was failed at home as a child, that her mother could have done more for them, and failed at school, life turned out well for Erin. Her religious activities, participation in a tenants association, a good marriage, regular income, support from mother in law

are clearly beneficial, her tolerance of others is an added dimension. Without these things Erin's quality of life, her mental and physical health may well have turned out poor like those in the Similar and Restricted groups who had experienced unhappy childhoods and had babies young. Erin's health is excellent however. She is looking forward to the future (unlike many of her contemporaries described earlier) and to her new house - on the estate near her mother's. She has plans for the future, she wants to go to College and become a social worker.[10]

Not all is plain sailing for these residents. Being involved can sometimes be a source of family conflict. Erin became a born again Christian three years ago. It caused some disagreement at home at first: "my husband is not a Christian, he was afraid I was getting into some sect." Similarly, Val has a very good relationship with her (second) husband, but he is not happy with the level of her involvement in local groups. "He says, 'don't you feel you've wasted your life, you should do a proper job and get paid for it, you could have achieved so much'."

The networks which are potentially most health protecting or promoting will balance egoism with altruism. Although potentially the balance is more likely to be achieved by people whose nets correspond to the solidarity model, for some individuals, altruism is more evident than egoism. Reciprocity appears to be the key. Val gives a great deal of practical support to her family and to her in laws. She gains a great deal from their appreciation and love. She also gives a great deal of support, including advice, to neighbours and other local people. For example: "Neighbours told me that an old lady had Alzheimers, but it was a battle to make the family come to terms with it". When she was in need of emotional support herself, Val used to rely on her old friend, who she'd known since she was seven. Her friend however, died three years ago. Val misses her desperately and now has no real confidant. Throwing herself further into the affairs of the Tenants Association and the projects she is involved in helped her to cope however.

Val's health has deteriorated since her friend died. Back pain is worrying her, but "I can't get the doctor to take me seriously". Val clearly gives a lot, but, for the sake of her health, may be giving too much, and not receiving enough back. Altruism needs to be balanced by a little egoism. Sometimes she does feel resentful. She went to a meeting recently organised by the council, where "everyone there was paid except me." Val's experiences are a clear example of altruism being imposed on women, of women being exploited by agencies providing services. She links her situation to her perceptions of an unequal society:

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10 I have recently heard that Erin is now a student.

> "The share of wealth is totally ridiculous. I don't begrudge people having plenty, but they are using you, living off you. Take the rises in parliament - they get all that yet they expect people like me to work for nothing. John Major doesn't care. The professors should be listening to people like us, finding out about us, then perhaps people like us would get employed. They expect me to work for nothing, but if I didn't do it, it wouldn't get done. I fought hard to get the blocks done up, and I fought hard to get SRB money."

There are similarities between the cases of Val and Agnes, they both give a great deal. Agnes is a nun living locally and working on a local project which aims to involve local people. She is usually in excellent health, but has in past suffered from exhaustion when trying to do too much, when continually putting the needs of others before her own. She felt out of control at these times. Although she is very close to her family in Ireland, she is only able to see them once a year. In addition, she has little control over her personal finances, the sisters provide what she needs. At times Agnes appears to be slipping into aspects ofPluralistic model- there is not enough time for herself, or support for herself. At times she can feel isolated, her leadership role in project work is a lonely one.

Vilma (41) however, a lone parent with four children who works for the DSS, seems to have got the balance right. Though highly active in a voluntary organisation, in her case, she gains as much as she gives. Unlike most in this group, she is not a local woman (originally from Nigeria) and has worked hard at building up her networks. When I visited Vilma, it was the school holidays and the house was full of children - her own and friends': "I'll help anybody, my family were like that". She keeps in regular contact with her parents in Nigeria. She has a wide range of friends, both local and non local, and keeps in touch with her old friends from Lesneys toy factory. Her networks closely correspond to the Hirsch model, with several dense clusters and loose density overall. The contacts she has made through her activities are a separate group from her work friends and local friends.

Vilma is an active member of the West African Women's Association, an organisation whose activities are not focused on the estate, but include members from across East London . This interest community acts as a source of mutual support: "We support each other, when black children are in trouble we try to help and advise parents. We also help single parents, and battered women, and take children out for activities." She finds participation in this self help association both enjoyable and helpful to her: "Its satisfying, meeting people, and it makes me happy to help someone who is suffering. We have social gatherings too". She gains in practical ways, and is able to compensate perhaps for not having her family nearby, or indeed in the country: "Sometimes I

have difficulty feeding my children, then they will lend me some money". The group also share information, and her comments suggest that self help groups can play an active role in stemming any decline of values held to be important : "We try to teach children morals and our culture". Vilma's lifestyle and activities stand in contrast to the lives of the young people in the tower blocks described earlier, where a decline of values was reportedly evident.

Most in this group - Chris, Henry, Vilma, Erin - and Agnes and Val when they don't overdo it - have excellent health. They could be a self selected group of course, pre-existing good health may mean that they are more likely to seek involvement than others. June however, a relative newcomer, says she is feeling fitter since moving to the estate and joining the Tenants Association: "I feel happier and have lost excess weight. I'm getting out and about". June also links her good health to having both family support and outside support.

With so many commitments, especially work and children (she is divorced and has four children) it could be expected that Vilma's health would suffer. She could be expected to be suffering from "overload." To make ends meet, she does two jobs: "On a typical day I wake at five, do a cleaning job for 2 hours, come home, take the little one to school, then I go to work at the DSS office". She would much rather work than live off Benefit, even if the money were at a comparable level. Her health however, is excellent. Although she puts this down to luck: "I'm lucky, God has made me strong, we people from Africa are strong. " The composition of her networks, which provide a wide range of support and access to resources, are likely to be protecting her health. Her attitudes to mixing with a range of people, of seeking shared interests with others affect her predilection to broaden her networks.

Like Vilma, June, a thirty two year old single parent, is not a local woman. She has lived on the estate for only 18 months, but already is well integrated into local life. June and her neighbours give each other mutual support and share childcare, she is active in her Tenants Association, and she has made new friends. June has a supportive family in Walthamstow, siblings with whom she is on good terms and "friends all over the country". Some of her friends she made while working in Walthamstow market and the Dog Track. Not all of the people in her networks know one another. If she is ill she can ask anyone for help: "the first person to put their head round the door". For financial help she can ask her family or neighbours. She has gained a lot from her participation in the tenants association,: "I joined because I was getting bored, since joining my mind has been more occupied, it makes you more aware of people's problems, and your own problems do not seem

so big". Like many of the others interviewed in this group, June stressed the satisfaction she derived from involvement: "It gives you a good feeling, a sense of achievement, that you have helped".

Although June, like many single parents on the estate, has to survive on Income Support, she thinks that she is better off than some others: "My kids are not always asking for things, and I don't give them money to go out, I take them to the park, I have more time for them. Bills are difficult though, I go without to pay them." June is clearly able to cope.

Attitudes and reference groups

The distinguishing features of the Network of Solidarity concern reference groups and attitudes to society. People in this model are motivated by their perceptions of inequality. None believe that we live in a fair society, Chris was not alone when she said 'there's one law for the rich and one law for the poor'. Agnes perceives wide inequalities: "I've seen such wealth, and such poverty, such inequalities. The children round here are so poor, and the schools and hospitals are so short of money". She believes that she as an individual can't do very much to change things, but that when working with others she can: "I can do something to help, real community work is about people getting together to help each other". Val is active because she hates poverty and injustice. She also has a strong sense of history: "Anger has driven me... When the dockers were on strike, then Father - a boilermaker - was on strike too. The Nuns came round collecting during the strike, and Mum said Sister, I've only got threepence, and I need potatoes", and the Nun said "you can give me half". Memories like this help to deepen commitment to local people. Like Bessie in the Pluralistic group, she is also driven by a desire to do something for her Grandchildren, so that they can lead better lives than people of her own generation. June is also strongly motivated to achieve change: "We council tenants deserve to be treated with more dignity, the council officers treat us badly, they will get back to us about problems when they can't be bothered. They are letting council estates go to ruin...if the council won't do anything, we will do it ourselves".

People in this group have strong hopes for a better society. Agnes for example: "I'd like to see a more moral Britain, and a more equal one." Many of the individuals in this group display definite attitudes of social consciousness, including class consciousness, and all have positive attitudes towards people in different ethnic groups from themselves. Agnes, for example, sees Britain as very class orientated : "there's the aristocracy, the middle class and working class." June sees the main groups in society in terms of classes, and puts herself firmly in the working class group. Vilma has a definite class consciousness: she sees a growing divide between the rich and the poor: "I'd like to

see the poor being able to live a better life, have an average standard of living, but now they have no hope. The rich do alright, they don't know how the poor live". She divides Britain into two main groups:

> "...the Tories and the rest. The Tories don't do anything for the poor in East London, just look at the schools, look at the lack of hope."

Vilma always votes Labour. Vilma, and the majority of this group - would like to see more jobs, especially for young men, and more help with childcare.

All of the residents in this group describe themselves as great mixers. Chris for example: "I find everybody interesting". In a sense all people are important to Agnes. She mixes with people of all and no faiths, and does a lot of work with refugees. She stresses that there is a lot of misunderstanding in this part of London about the needs of refugees. Vilma also identifies with a wide range of reference groups: "I have black and white friends, Jamaican friends, African, and workmates...I mix with anybody, I believe in being friendly and loving one another". The only group Val and June have antagonistic feelings towards are racists. Agnes described her own attitudes, reference groups and her perceptions of community succinctly:

> "I see the poor and unemployed here, both ethnic groups and native East Enders. They are wonderful people, I love them, they are a people apart, a culture of their own."

People like Agnes are as committed to their community as the residents in the Similar and the Traditional networks, but here, the community is wider, much less exclusive, much more inclusive. Agnes added: "The more ethnic groups you have in a society, the richer it will be."

Of course, it is not possible to judge which came first - the attitudes to mixing or the involvement in organisations. Personal history can have a influence. As June put it: "if I like them, I mix. I'm probably different to people round here, I've got mixed race in my family...and one of my brothers is gay". June recently gave support in a way which illustrates the breadth (by Canning Town standards) of her reference groups: "I stood up for a gay teacher who one of the neighbours was giving grief". Val has lived a varied life job-wise, as a professional dancer - when she worked with Delaney and Ted Heath, a cook, and working in a pub. These early experiences, which included spells abroad, have she believes, helped to give her a different outlook on life. "I'm not as blinkered as some people from Canning Town". She has sympathy with a wide range of groups, including single mums, because she was in that position herself, when her first marriage broke up.

People with networks of solidarity can be influenced as much by religious conviction as a desire to

tackle injustice and inequality. What they share is a wide range of positive reference groups. Erin for example, sees many others as like herself. Becoming a Christian has changed her attitudes:

> "I started to see things differently, I don't hold grudges anymore. You also care about people more, other than friends and family. You become less selfish: round here its 'you look after your own, don't let others take liberties'. Now I look further afield, I don't judge people. We had a rowdy family here in the flats but I realised they must have had problems, and may need help. When I hear the mums and children swearing outside the school, I realise that they must have problems too."

Materially, she considers that they themselves are lucky. Her husband is in work and they are planning to buy a house. She would like to see more people changing their attitudes;: "I'd like to see people accepting of others more, like refugees. We should also give more to the starving in Africa".

Henry is the only one of this group, who although he has a wide range of membership groups, has general attitudes and reference groups which do not fit the Solidarity model. He believes that Britain is: "only fair to foreigners and outsiders, but not to our own people. I get a pension from Tate and Lyle, and can just about manage, but I can't apply for anything else. Yet immigrants can get everything". Unlike the others interviewed, Henry is a member of the Conservative party.

Life experiences and attitudes to health

Several of those interviewed believed that now was an especially good time of their lives. Val, for example, was experiencing the stability of her second marriage, and Vilma the stability of being single. One woman mentioned specific incidents: "The day I met my husband, the day I had my first baby, and when God entered my life" (Erin). For all in this group, their quality of life was connected with the satisfaction of present involvement in local life. Like some of those in the previous network - Pluralistic - taking responsibility for your life was also important : "Life is what you make it" (June). Interaction with others, and the satisfaction that gave, also emerged as an important strand of their attitudes.

Life for Chris, has always been good: "I can't think of a time when it wasn't. She particularly enjoyed her time working in a factory when she was a young teenager: "I loved it, the feeling of being part of things, we all stuck up for each other".

Some spoke of unhappy times in the past, but the tendency for those in this group was not to dwell on it, what was happening *now* in their lives was what mattered. Val for example had an unhappy childhood and a history of poor health, including a breakdown at 7, and was very unhappy during her first marriage, at which time she suffered post natal depression. She feels however, that these

earlier experiences are now behind her.

As expected, bereavement was again mentioned as an instance when life was not so good. However, a combination of high levels of participation plus good levels of personal support helps some to deal with it: "Life was bad when I lost my mother, I had a bad attack of... [a neck complaint] but I pulled myself out, because I know there is someone out there who needs help more than I do, so you get out and do it" (Barbara). They are able to withstand a certain amount of stressful life events, not in the way of those in the Traditional model by 'getting on with it' but because they have built up social capital, they have a wide range of support and advice to rely on, as well as outlets for their energies.

Keeping fit, getting out and about, were seen as important for health by many in this group, as they were for the Pluralisitc group. Henry for example believes in the importance of being active to keep both the body and mind going: "Some of my colleagues stopped work too suddenly and died". Another commented: "The more you get involved in council work the more active it keeps you, and you are meeting people," (Barbara). Barbara had seen a lot of senile dementia locally. It happens to the elderly, she explained, because they stay indoors, when they feel that no one wants them. But she had noticed it occurring amongst people as young as in their forties - brought on by the sudden departure of someone, or the loss of a job, or the loss of earnings. "They tend to be people who are a bit isolated, because, for example, the job has always been their personal life, or they have been a bit elitist with the neighbours, or don't have large families".

Some mentioned the importance of what you eat, drink and smoke, and some stressed that not everyone could afford to eat healthily. The behaviour of others was seen by one woman as detrimental to the health of residents: "There's a TB epidemic again, because people spit round here. When I was a girl you were fined if you spat in the road," (Val). Like the Dissimilar group, some were critical of local health services, and one thought that "...the filthy doctors surgery and the filthy hospital..." (Val) could themselves cause illness.

One woman believed the appearance of your home and neighbourhood was important for health. She also suggested (although young herself) that younger residents did not share the values of the older residents concerning litter; "I can walk into my flat and its nice [it is]. Sometimes I walk round here and it makes you feel down, with the young residents there's a lot of litter and vandalism. In mum's road however, its nice and tidy and people have done up their houses," (Erin). One resident, like one noted earlier in the Traditional group, saw the home as important for health

because the home housed memories: "I was told that the council wanted to get me out, because a councillor wanted this house, so I bought it. My memories are here. If you have a plant in your garden and you shift it, 9 times out of 10 it will die. Your body is like that," (Henry 78). Not everyone of course has the necessary financial resources to protect their health in this way. It is pertinent to note here that residents in Networks of solidarity were comparatively well off in certain material resources. Almost all were hard up financially, but all were content with the accommodation they were living in - either terraced houses or ground floor flats. Its much more difficult to find the motivation to get involved in things if other aspects of your life - such as poor housing, or difficult relationships - dominate your life.

Although there were similarities in views on health between the Solidarity group and the previous groups, residents here identified a much wider range of social, economic, environmental and political circumstances which could affect health. .Some mentioned the living and working environment, including the effects of industrial pollution, and the toxic effects of work itself. Val's friend worked in Lesneys, making lead toys, and died some years after exposure: "No one told us about the dangers of lead poisoning when we were 15, but they must have known about it" (Val). Val's husband is a big man. He was given all of the heavy loads in the docks, now crushed discs have made him an invalid. The effects of not having work, or being in badly paid work, was also mentioned by several in this group.

Vilma's wide range of reference groups and lack of parochial and insular attitudes is reflected in her views on health. "The health of children in Somalia is affected by circumstances, by war. They don't see food or water. Me, I have everything, so my health is not affected". Another resident looked to the national political climate: "..women suffered under Thatcher, and their health suffered. She did nothing for women".

As with people in the other models, relationships were seen as important for health and well being. However, feminist consciousness, as well as the class consciousness mentioned earlier, was also evident, and some women made direct connections between gender relations and health. People in the network of solidarity model were either in good, supportive marriages, or if single, valued their independence. "One of my friends split up with her bloke. ... She tells me that she needs a man, I say, just get on with your life. I don't see why some people have to rely on someone to get through life", (June). A woman who had once been with a violent husband but who now had taken control of her life believed that the unequal distribution of power between men and women was a causative factor in ill health. "Men have power over women and we let them...that can can spark off illness"

(Jan). Val added: "If you are content and happy with someone, you are content with life. Working class men need to be re-educated, because working class women suffer. You need to be able to talk to your partner".

For some in this group, a supportive partner was considered an important ingredient for good health. "I've always been able to pull myself out of it when I have problems, when I lost my mum and my sisters for example. I have a good husband, that helps and get strong support" (Barbara). "I've got a good husband, that's got a lot to do with my good health", (Erin). Comments on support were not restricted to partners. Erin described the benefits of a good family: "If you get support and understanding, you feel good. If you are stressed you can break down, but if you have people around you who will help you, you will have better health," (Erin). June, interestingly, linked strength of character with support: "circumstances can affect health, but it does depend on what sort of person you are. If you are strong, you can get through it. If you've got family support and outside support, then that helps you to be strong" (June). Receiving support however, was not the same thing as being dependent on people: "None of us depended too much on Mum and Dad, they taught us to be independent, with minds of our own." Chronic dependence of children on their mothers was a feature of families attending Newpin, and described earlier. The dependence of adult women on their mothers was also a characteristic of some of those described in the 'Similar' group earlier. Coping with life, and protecting health, appears to be something of an interactive process amongst those in the solidarity group.

Coping

A common theme in these accounts concerns how people cope with life, poverty and health. Differences in coping and perceptions of coping emerge from the different models, in particular these concern passive coping, active coping, and interactive coping.

Residents respond to poverty in a practical sense by adopting coping mechanisms . How they cope is very much linked to their social networks. The extent to which they are able to cope has implications for their health. People with more restricted models - the Restricted or narrower end of the Similar group - don't cope. They lack resources and help, and are, and perceive themselves to be, powerless. Many on the estates turn to smoking as a coping mechanism, or take anti-depressants. These are perceived as helping them to cope with debt, stress, bereavement and relationship problems.

The extent to which the Similar model cope depends to some extent on the quality of relationships

in the network. Family members provide support, such as help with childcare or financial support, but it frequently is not enough to meet needs, and there may be family conflict. Friends can provide emotional support, but because membership groups consist of people like oneself, they are not able to help with accessing other resources, such as information, including health information. The tight knit structure of the networks mean that network members can provide little relief when negative life events - particularly bereavement - strike.

Those in the Traditional model cope, like those in the Similar, with a certain amount of mutual aid. This is particularly clear in old age, when friends shop and cook for each other, and family members help during illness. Participation in social clubs brings many benefits. It keeps people active, they are pleased to be doing something for others, and they can indulge shared memories. The Traditional group lay great stress on the value of coping in adversity, of getting on with it, taking what life throws at you, not making a fuss. They have similar attitudes to coping with ill health. Although these traditional East Londoners believe that keeping active is important for health and well being, it is still something of a *passive*, fatalistic kind of coping. They don't seek help, or try to remedy situations from external sources.

The Pluralistic group cope *actively*, they are well informed, they are able to access a range of resources to help them cope with poverty. They gain real feelings of achievement from involvement, and have a sense of personal control. They believe in taking responsibility for their own health, they take notice of health promotion advice and act on it. There is no defeatism in their attitude towards poverty and inequality. They believe that change is possible and see an active role for themselves in the process.

Residents whose networks correspond to the network of solidarity cope *interactively*. Like the Pluralistic group, they are active, but like those with Traditional and Similar networks, can access the support of close personal ties. Their wide range of reference groups means that they are willing to interact with a wide range of people who are both dissimilar and similar to themselves. They cope reciprocally. They are able to withstand a certain amount of negative life events, not by 'getting on with it' but because they have built up social capital.

9. CATHALL ESTATE

Like the chapter on the Keir Hardie estate, the first part of this chapter provides a brief community profile of the area. It looks at facilities and services, housing, and the reputation of the area. These provide an indication of some the opportunities which exist locally for residents to develop and maintain health promoting social networks. It also looks briefly at demographics, levels of poverty and unemployment, and health standards in the area. The second part goes on to explore residents' accounts and perceptions of community life more fully, and the implications that these accounts have for social networks and for health and well being. An aim is to identify features of local life which can 'include' people into their local community, and which exclude. The chapter on Keir Hardie indicated that structural and other factors influence opportunities for social networks. A second aim of this present chapter is to is identify similarities and differences of community life on Keir Hardie and Cathall and to asses the extent to which these are determined by the structural and subjective features of the neighbourhood examined.

A PROFILE OF CATHALL ESTATE

Cathall estate is located in the Cathall ward of the Leytonstone district of the London borough of Waltham Forest. Although Waltham Forest is an outer London borough, its southern half (of which Cathall is part) has many of the characteristics we associate with the urban decay of inner London. These include poor housing and poor environmental conditions, derelict and semi-derelict sites and run down shopping centres and facilities, (LBWF,Autumn/Winter 1993). The estate is in the Cathall ward, an area characterised by a dense mix of residential and retail properties, with very little green space accessible by local people, (South Leytonstone 1996/1997).

Despite similarities in the profile of residents in terms of poverty, deprivation, unemployment, and a high proportion of single parents, Cathall is a very different estate in many respects to Keir Hardie. It is not cut off in the same way from the surrounding area. Access to and from the estate is relatively easy, and people living outside use some of the facilities on it. It also has also been on the receiving end of policy interventions and regeneration. The estate is now undergoing radical redevelopment as a Housing Action Trust (HAT) estate.[1] Physically, the area covered by Cathall estate is smaller than Keir Hardie in South Canning Town, though there is something about the

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1 See Appendix..

uniformity and drabness of the buildings (before re- development) which makes it *appear* unending. Like Keir Hardie however, the local shops are now boarded up.

Reportedly described by Prince Charles on TV as the most badly designed in the country, before re-development the estate was a dismal sight. The external appearance of the housing is ugly and alienating, particularly the elongated low rise blocks with their oppressive endless concrete walkways. It is no wonder that a resident dubbed it "Alcatraz 2". The flats are only 24 or so years old, but already they are crumbling. Until recently there were serious and widespread problems of overcrowding. A professional working on the estate reported that " Four children living in a one bedroom flat was not uncommon. It was crisis housing. Since the HAT took over the situation has vastly improved, and you can see the difference in the health and behaviour of the children". The estate is now a Housing Action Trust area. Tenants, with help from various agencies, including the Local Authority, fought hard to get HAT funding and continued to fight to ensure that their views and needs were heard and responded to. Some of the old blocks have been demolished and new terraced houses and low rise blocks built, and occupied. The majority of tenants however may have to wait some years before the bulk of the older flats are demolished and they can move into new homes. [2]

Leytonstone High Road- with heavily congested traffic- is adjacent to the estate. Traffic congestion is expected to be eased once the nearby M11 Link Road is complete. The area is well served by public transport. There are shops and a library in the High Road, but the former have declined in numbers and quality since the local department store shut a few years ago. the general impression of the wider area is one of decline. However, the estate itself is quite well provided with services. A swimming pool/leisure centre borders the estate, as well as a primary school, and an Adult Education Centre. The HAT have recently built a community centre-the Epicentre- in the middle of the estate. It appears to be less of a community centre in the old sense of estate social clubs, and more a venue for voluntary groups and meetings.

The primary school is used by residents both on the estate and from the surrounding residential streets. Nearby streets are quiet small terraces, with a population like the estate's which is

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2 As well as HAT regeneration, an SRB bid includes plans for the creation of an Urban Park on the Langthorne Hospital site, near the estate. It will provide green space and a community building with a Techno cafe and IT training facilities. (South Leytonstone,1996/97). The bid partnership also plan to encourage business investment in Leytonstone High Road, increase educational attainment of children in primary schools, and create job opportunities.

ethnically heterogeneous. These streets appear cohesive and relatively trouble free. The HAT are buying up adjacent terraced properties and selling at a discount to Cathall tenants to ease the demand for new homes on the estate, and to integrate estate residents with adjacent residents. Additional nearby local features include a long stay hospital for the elderly - once the workhouse- and a cemetery. This is a heavily built up area. There is no park or green field anywhere near the estate.

The importance of casual meeting places for establishing a sense of community and fostering the development of social networks was explored in the chapter on the Keir Hardie estate. Local meeting places on Cathall include the primary school and nursery, and two children's play areas below the old flats. Otherwise, people appear to hurry through the estate. This is one of the striking features of Cathall: there is little in the way of casual interaction on the streets, walkways or landings, few people stop to greet each other. Some local women are resourceful however: a cafe in the High Road is a regular meeting place in the mornings after they have taken their children to school. There are indications that the new HAT built terraced houses are more conducive to community directed behaviour amongst those living in them.

Despite the general air of hostility, the estate does appear to be better provided with projects and initiatives than many neighbourhoods. The area has a sustained and effective history of community development work, and of input by local voluntary organisations. Long term outreach work by council employees- such as an educational visitor- has done much to develop residents' social networks. Co-operation between the various agencies, including the police, appears effective.

A great deal of work goes on on the estate and its surrounding area to encourage people, especially women, to make contact with others, and break down some of the isolation endemic on the estate. Childcare groups, community development work, the Cathall and Avenue women's project, are amongst those involved. The educational visitor runs a toy library on the estate, and does outreach work to encourage people to come along. Sometimes it can take a long time for someone to gain in confidence to mix with the other parents, and then to go on to join other groups. "One woman came for months and would only sit in the coat corner". Although estate residents are targeted, the generally hostile environment of the estate may act to discourage their involvement. Although attendance at the toy library is good, and people from many different ethnic groups and nationalities go along, surprisingly, few of those who make use of this facility are from the estate. On occasions I visited, there were none. The Educational visitor offered an explanation: "its the isolation of living in a flat, and the design of the flats and inadequate lifts makes it difficult to get

out with young children". The very poorest groups tend not to get involved in the toy library. "They may feel shy or intimidated in large groups, or they may feel afraid that their child may play up. I visit them and tell them that I want them to come along for that reason, so that their child can get used to playing with other children", (Educational visitor).

Isolation can be a particular problem for refugees, but outreach work is helping them to develop their networks: "I know a Somali woman living on the estate who can't get out, she has two babies but only one buggy, and she doesn't speak English. There is a network of Somali families on the estate who help each other with childcare etc. I visit them and introduce them to each other", (Educational visitor). The Cathall and Avenue Womens Project focuses on low income women who do not have paid employment, particularly working class and ethnic minority women. They provide free courses , on childcare for example, and provide a creche. A current diploma course is targeted at Somali, Asian and West Indian women. Going along to courses has for some, led to increasing their involvement in other things. Sofia for example, started off with courses, and now runs groups for Asian women. She is also instrumental in persuading them to go along to courses put on by the Women's project . "Asian ladies said we don't need courses. I said its different, try it, now lots do the courses. They learn about their children's education, and food ",(Sofia 48). The majority of residents however, do not take up opportunities like these.Years of experience of living on Cathall can have a stultifying effect on residents. One resident explained why more women don't get involved: " There are courses you can do here, but people feel, why bother, because no one ever gets anywhere on this estate, " (Sonia).

There is a good level of provision for young children. A recent innovation is a childminding network, based at the Epicentre. It provides training, drop in sessions for childminders, help with finding minders, equipment loan, and advice. A longer established facility is Hollycats Community Development Association which began in 1982. It is involved with childcare; Somali support work; a children's breakfast club, a community computer resource; childminders drop in sessions, and various child care schemes. It supports a group for gay young people, and gives space to a refugee advice centre. Organised activities are a lifeline for some residents, but it is clearly important that they are of the right sort. "I went to a mothers group at the Jubilee centre [Adult Education Centre on the edge of the estate] but did not feel welcome . There weren't many there from the estate, they were from all over, and I was the only black there. I went to the toy library though, that's very good, and Barbara makes you feel welcome ",(Elsa).

Although small children are comparatively well catered for, residents feel strongly that older

children (like those on Keir Hardie) have been neglected. Sonia points to the lack of facilities and play space available:"There's not enough for them to do. There is Hollycats, but unless you are a troubled family, or work full time, then your child can't go. The adventure playground scheme after school isn't very good, they don't control the kids, and gangs pick on some of them. There's nothing for children at the new Epicentre, and they took away some of the children's play space when they built the warden controlled flats on the old adventure playground". Bored youngsters cause problems for residents, several complained about the behaviour of children on the estate. For example: "The youngsters are more active at night. If you have a car, never leave it round here, the kids throw stones on them from the balconies", (Barry, 81). " Kids in gangs go round setting the chutes alight, the fire brigade can't wait for the estate to be pulled down ",(Sonia). Residents blamed neglect on the part of parents, as well as lack of facilities. Some of the more resourceful did not let their own children play on the estate. "Little children run around all hours. I don't let my children play out on the estate " (Lucy, 32). " I don't let my 12 year old play out on the estate, because there always trouble and fighting ", (Anna, 32). Sonia doesn't want her children to go around in gangs like other children on the estate. She encourages them to go swimming and dancing elsewhere. "I want my kids to have careers, I don't want my daughter to get pregnant at 16 or 17. That's what they do round here, they experiment with sex at a young age. There's a high percentage of black boys and white girls who hang around with them."

Badly behaved children are now no longer solely a problem for the estate. A professional reports that some of the new houses are facing outwards from the estate. In one sense this may cause problems for adjacent residents: children no longer confine their - sometimes anti-social- activities to the estate.

Cathall is a highly stigmatised area, not only in terms of public perceptions, but it is a stigma which has been internalised by many residents. Its bad reputation was derived in part from an influx of "problem families" in the 1980s, and from (until recently) high crime levels. Its reputation as a high crime area has reached as far as the Keir Hardie estate, where a resident said "I wouldn't visit Cathall during the day, never mind at night". A cab driver remarked to a Cathall resident, " oh Cathall estate, that's where you can buy an ounce of coke in the sweet shop". "But rumours, like this" stressed the resident, Don, who is active in community development work on a voluntary basis, " and the way this place is defined have no reality". Professionals - though not most residents- appear keen to try to redress the poor reputation of the area by playing it down. A local vicar, for example, believes that the stereotyping of the area came from people largely living outside it. Negative perceptions were evident in some of the interviews with people living near the estate. For

example: "They are trying to knock it down because of the drugs. I've seen police chasing people on the estate. It used to have a terrible reputation, at one time the postman wouldn't deliver, and people won't walk round it at night", (John, 64). [3]

Professionals report that fear of crime is certainly a salient feature of the estate, as are fears for personal safety, on the part of women, the elderly and local teachers. A survey conducted for Waltham Forest council reported that law and order and crime were mentioned by as many as 22% of residents surveyed in Cathall Estate as the worst thing about living in the area, compared to only 4% of those living on the nearby Cann Hall estate, (LBWF, 1994). Poor perceptions of the area, fear of crime, are detrimental to health, both in a direct sense, because perceived hazards impact negatively on health, particularly mental health, and indirectly, because such perceptions discourage interaction, involvement, and the development of social networks.

The community policeman explained the basis for the area's poor reputation, and for its (until recently) high crime rate. "The design of the estate assisted in generating crime. Flats were easy to break into, there were high levels of car crime because people couldn't park near their homes, and, because there were so few play spaces, graffiti and vandalism were rife". Another professional suggested that fear of crime on the estate was very much exacerbated by the design of the buildings. "Its eerie, on the ground floor, there are just blank walls". During fieldwork, I found gaining access to the flats to be an alarming experience. The visitor is faced with long tunnel like windowless corridors on the ground floor. The location of the flats is also problematic: flats are grouped in threes on a corridor. One will be on that level, another the level below, and another upstairs. You can enter on the third floor, but you may live on the second or fourth. Consequently, if residents are unfortunate in having troublesome neighbours, it can be very difficult to know who they are. It is not easy to identify the source of noise problems for example. The new houses are built to a conventional design. It is easy to identify anyone who is causing problems.

On the Keir Hardie estate, housing allocation policies- by attempting to keep old neighbours together - had helped to foster a sense of community on the estate. Here on Cathall however, housing allocation policies appeared to play a major role in aiding the area's decline. Residents were highly critical of the so called'dumping ground' policies of the 1980s. A police officer described the estate's decline in terms of housing design, crime, and housing allocation , and the inevitable consequence of high turnover of residents. "So, people had little desire to stay. If they

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3 There were 1409 reported crimes in the Cathall ward in 1993/94.

could leave the estate, they did. The area became stigmatised, and the cycle of decline became entrenched. Decent people didn't want to live on the estate, only those who had no choice were left or ended up there. Housing policies didn't help. You'd get a large family in a flat, next to an old age pensioner, next to a person who had just come out of prison. In fact, if you have a problem, whether its social, economic, or a criminal record, then the only place you are likely to get a flat is on the Cathall estate." Residents were also understandably concerned about paedophiles being housed in the flats, this made them even more worried about their children playing out.

The police officer added that he was working closely with the HAT to design out crime, and that it was working. Forced entry burglaries were now at a low level. He does not, in any case, believe that the area's reputation as a high crime area is altogether justified. "Homes around the estate now have double the rate of burglaries as homes on the estate. A cynic might say that all the burglars live on the estate [a point reiterated by residents] but the terraced houses outside are now easier to get into. But people have long memories, and the highly stigmatised reputation of the area persists".

In contrast to the majority of Keir Hardie residents, fear of crime emerged as a key point in interviews with Cathall residents described later. It was not only *fear* of crime which damaged community relations and acted as a block to community cohesion however. Experience of crime, as victims or witnesses, emerged as key issues for a majority of those interviewed, even though no direct questions were put on this topic. A victim's support group has recently been set up and operates on the estate.

Cathall is not an area of stable population. Until recently there was a great deal of movement on and off the estate. Since the HAT began its operations however, the population has become more static: people are not moving out because they are waiting for a new property, (Educational visitor). This is clearly important for the estate's long term future and development. Demographically, the area has more in common with inner London than outer London. The estate has a high proportion of children, it is ethnically mixed and there is a high proportion of single parents. The Cathall ward as a whole has the highest (and growing) proportion of children in the borough: in 1991 the proportion of the population aged under five was 10.5% and 7.9% were aged 5-9. The proportion of under fives in the borough as a whole is only 7.5% (LBWF,1994(b);Cattell,1997). 34% of the resident population in Cathall ward are under 24. 43% of the population belong to an ethnic minority group, the highest proportion for the borough as a whole. As on Keir Hardie, unskilled and semi-skilled classes predominate, 23.2% of the ward's population belong to social classes IV and

V, semi skilled and unskilled, compared to 17.6% in the borough as a whole. (LBWF, 1995; South Leytonstone, 1996/1997).

34.3% of households in the ward contain children, and the proportion of lone parent households, at 12% is twice the average borough rate (LBWF,1995). A high proportion of those residents moved onto the estate during the 1980s were reportedly teenage mothers, (Hollycats worker). There are also people on short term, insecure tenancies, who will not be re-housed by the HAT. Some of these are refugees, and are amongst the poorest residents, (Community Development Officer). Somalian refugees tend to have large families. A professional reports that "there are 7 Somalian families living on the estate, with 38 children between them. One family has nine children, its a cultural goal to have lots of children". The very high proportion of children on the estate may have been reduced since the HAT arranged transfers to street properties for some families.

Cathall is a very poor estate in a very poor ward. On the Index of Local Conditions, Cathall has been identified as the 17th most deprived of all wards in London. Like the Keir Hardie estate, a high proportion (58%) of ward residents do not have access to a car, (South Leytonstone, 1996/1997), compared to 42.9% in Waltham Forest, and 40.7% in Greater London. Poor families with children are a feature of the area. The proportion of children living in unwaged households is over 40% in Cathall ward. Almost half of all large households in the ward (3 or more children) were in unwaged households. According to the Educational visitor, very few children living on the estate have holidays away, and many seem to be poorly fed. Unemployment in the ward is especially high - 15.1% for women in 1991, and as much as 34.6% for women living in council accommodation. Male unemployment was 22.5% in 1991. For the borough as a whole, female unemployment stood at 9.3% in 1991, and male at 15%. The ward had the lowest proportion of males in full time employment (53.5%) in the borough.(LBWF Autumn/ Winter 1993;Cattell,1997). Official unemployment rates continue to be high for all age groups, and stood at 19.4% for men and women in 1995. (LBWF, 1995(c;d). We could expect poverty and unemployment figures to be higher for the estate itself.

Poverty, people struggling to make ends meet, is seen by professionals as the biggest problem on the estate, as is the very high level of unemployment. People who want to go to work are caught in the poverty trap : "If they come off benefit however, they don't earn enough to cover their outgoings, they lose benefits like free school meals. I spend a lot of time trying to explain this to people. People have tried going to work and found that they are worse off. I try to persuade them

to go on courses instead", (Educational visitor). Going on courses is seen as a way of alleviating poverty, or coping with it, by a number of people working on the estate, and by some residents themselves. What is particularly interesting is that courses are perceived as a kind of substitute work. Some of the benefits to health we associate with work may well be provided - at least to some extent- by going on courses. A local caretaker thinks that people need a bit of guidance: "London is a place where people don't look out for one another, people are looking out for themselves. I advise them to go along to a course, day release and college, and HAT courses. A lot of the young girls feel quite good about it, even if it just means learning to use a keyboard. They feel so proud of themselves ", (Caretaker).

The caretaker, who, in seven years of working on the estate has built up a great deal of local knowledge, says that almost everyone living on the estate has problems. His perceptive comments link giving up, an inability to cope, and a breakdown of values, directly with poverty: "A few of the mothers find it difficult to cope with their children. Poverty gets them down, parents whose kids don't come in at the right time, they don't go looking for them, they can't be bothered, they give up. Some mothers are struggling because they don't get help from the fathers".

Although the new HAT houses are alleviating the deprivation and isolation associated with the old housing, some people will find it difficult to afford them, especially if they are not on benefits: "They received a letter last week telling them that their rents had gone up, and they now have to pay water rates, which used to be in with your rent. For those who have been on the same income for years, it's difficult for them. They may have been used to paying a rent of £45 per week, now they have to pay £65, and water rates on top of that"(Caretaker). Getting into debt is commonplace on the estate, and moving into a new home may lead to people incurring more debts. "A lot of people are on HP and on catalogues, so that they can get stuff for the new houses. Cards and catalogues are left at the door, the cards might be offering to make new curtains for example. People would like them but they can't really afford them. Its frustrating, you see these things and you can't do anything about them. You'd like to see people content and happy, but a lot of people live on the edge, with financial problems, and not being able to cope"(caretaker). According to one resident, Christmas is another cause of debt: "In the run up to Christmas people are just grabbing credit", (Jill, 30s).

Chapter 6 confirmed the relationship between poverty, deprivation and poor health at the regional and borough level. The relationship, as expected, is evident at the micro scale. Good health is not

a strong feature of Cathall ward. Indices of need, including Jarman , give it a high score. [4] The standardised mortality ratio is 112, considerably higher than the borough ratio of 97.5, and infant mortality rates and stillbirth rates are also high. In 1991 as many as 14% of ward residents have a limiting long term illness, compared with 12.5% in the borough and a Greater London average of 11.8% ,(South Leytonstone, 1996/1997).

Good health is not a strong feature of the estate either. The local vicar observes that people on the estate seem to spend a lot of time at the local hospital: "Whipps Cross features large in people's lives". A resident commented: "A survey says that 86% of residents believe their health suffered since moving here. Lots of people I know have physical health problems. Their problems are made worse by the psychological pressure of not being able to get out, and by the isolating environment", (Don, 36). Issues which emerged from a survey of health needs on Cathall estate carried out by the Waltham Forest Social Justice Unit, included lack of information on health issues amongst residents, difficulties in registering with a GP, particularly where language was a barrier, and lack of interpreters in surgeries. Frequently mentioned problems included isolation and depression. Amongst particular groups there was a problem of using Khat- a psycho-topic drug- by Somali men, and there are concerns about Somali female circumcision . Amongst elderly residents there was some evidence of lack of access to services, including chiropody. Wider issues include environmental health problems. Residents are living on a building site, with all the problems of noise and pollution which this entails. This has, according to the author of the report, a Social Justice Unit Officer, affected the health of the elderly in particular, in a direct sense, but also because they feel increasingly alone and isolated. Community Care, he suggests, has not been effective on Cathall estate, but they are now trying to arrange more visitors for the elderly.

Understandably, given the large scale regeneration being undertaken on the estate, a number of residents mentioned environmental factors in connection with poor local health. "The estate is unhealthy, there's dust from building works, car fumes, asbestos in cupboards, and dogs mess on stairs", (Elaine, 30). "They say there is more asthma here since the building started, and the children have more coughs" ,(Jan, 29). Dogs mess was until recently a real problem on the estate. Stairs and lifts are now cleaned regularly.

As well as environmental factors, professionals and residents cite poverty and financial worries, stress, diet, and lack of information on health issues as contributory causal factors to poor health

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4 The Jarman index is described in Chapter 5

on the estate. Children in the area appear to suffer from high rates of colds and minor infections. The educational visitor thinks this may well be related to diet: "I've been very concerned that some of the children come to school without breakfast. Their sugar levels are low, so they do not perform well. Hollycats have a breakfast club, but that's just for working parents. Some children come to school with bags of crisps in their hands- for their breakfast". Although she sees this behaviour as poverty related, she also insists that money is not the whole picture: " toast is cheaper than crisps". There may be evidence here that cultural values concerning heathy eating are breaking down, but as on Keir Hardie, the evidence is patchy. The health damaging effects of poverty and deprivation were more frequently cited. The caretaker for example, described a situation typical of many residents "[they are] living on the edge, with financial problems and debts, and not being able to cope. I speak to a lot of people, they'd like to be a bit more independent, and all these financial pressures affect their health. A lot of people would like to work, but that's a worry too, coming off income support, because they may not be able to manage, and that affects their health". Problems of overcrowding in the recent past had led to behaviour problems of children in school. Since the overcrowding has been eased, these kinds of problems have improved considerably. However, as the health visitor pointed out, the new houses may carry health problems of a different kind. Family income in the new houses has been further depleted by the installation of water meters, and the danger is that people may not use water when they need it. " There are worrying health issues here when people store buckets of water got from elsewhere ."

Residents themselves put particular emphasis on stressful conditions on the estate and their effects on health. For example: "Health on the estate is poor, because its very stressful here. People would move in happy, and 3 or 4 months later would be chasing each other with hammers. It's the bad design of the flats, you are cooped up, and there are no gardens...The health of single parents on the estate is very bad, but they hide it well" (Jenny, 33). Jenny links their bad health to poverty, isolation and housing conditions, as well as to the relationships they have with men. Problems connected with living on the estate, as opposed to one's own financial and household situation, cropped up repeatedly in conversations with residents. One resident thought that there had been improvements in health with the planning and building of the new houses: "Lots of people were depressed on this estate, and because they were depressed they were suffering from physical illnesses as well. ...once the HAT started, it gave people a morale boost, they had a say in choosing their homes. People don't mind going out now, and people are visiting their doctors less", (Jill). I noted in the last chapter that a health damaging lack of hope was a feature of certain, more restricted network patterns on Keir Hardie. Jill's comments are suggesting a reverse process here,

that once people have something to look forward to, then that encourages them to interact with others on the estate also. Not everyone shares her optimism however: "A lot of people are depressed here. Its such a depressing place. Two years ago a girl chucked herself out of the widow... Even those in the new houses are depressed. Its lack of money- they've put meters into the new houses, and everything costs more. They may be living in a nice house, but they have less money and more worries ". (Marie, 32).

COMMUNITY ON CATHALL

What are the dominant aspects of community life on Cathall? Although a working class area, there is little about Cathall to suggest a traditional working class community. There is no tradition of localised, large scale employment, less intergenerational continuity of residence than found in South Canning Town, and, most significantly, little of the neighbourliness we might associate with such areas. There is little sense of a territorial community, little sense of pride in the neighbourhood, and little interest in the area's history.

Some professionals were hesitant to describe Cathall in terms of community at all:"it's anomie rather than community here". Yet, as the Community Development Officer added; " it is unusual, there is more community involvement here in a formal sense than you might find elsewhere." Compared to other local estates, people "get involved more in events like community festivals, and projects like the Women's project" (Women's Project Officer). There are certainly more opportunities for involvement than on nearby HAT estate Oliver close, which I also visited.[5] Regeneration, but perhaps more importantly, longer term projects, are doing much to build up aspects of community life on Cathall. There is 'community made' for some.

Various agencies involved in working on the estate do appear to co-ordinate their activities. There is a community of professionals, if not of residents: "You don't get many estates where we all work together so well, like on the Carnival, or the under fives day."(Educational visitor). I visited the under fives day, and it appeared to be very successful. A wide range of professionals and voluntary organisations were taking part, as well as residents.

Residents' comments on their community differ little from the views of the professionals, though some residents put more emphasis on the lack of neighbourliness and trust. For example: "There

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5 A woman who had agreed to be interviewed on Cathall moved to Oliver Close at very short notice. She had reason to be afraid of certain neighbours on Cathall.

is no community spirit at all, they are ready to stab you in the back just to give them something to talk about. There's a lot of mistrust, you worry who you talk to. You have to be careful the way you look at some of the neighbours. I've got an injunction out now with her next door", (Sonia, 40). For several others, a lack of neighbourliness is recognised alongside opportunities to get to know people if you want to. For example: "Community, I don't know, I don't know if I belong" (Elaine, 30). After describing the high levels of burglary , graffiti and mess on the estate she added: "on the plus side, if you are a joiner there are plenty of things to do". Nasreen felt extremely isolated, yet even she could see some benefits to living on the estate: "The people on the estate are not friendly but organisations are very willing to help out whenever they can. The estate offers lots of projects and courses ", (Nasreen 22).

It became apparent during interviews, that even residents who are well integrated, in the sense that they participate in local organisations, or have friendship networks locally, do not appear to know their neighbours. For example: "Cathall estate is not a friendly place to live, it depends if you are involved in something. I'm doing a first aid course at the moment, I've met people on the course who have lived on the estate for as long as I have but I didn't know them! Its a shock when you realise that they've been here just as long as you" (Dawn, 30).

Accounts of community in the Cathall estate and Leytonstone area of the past

References to community life in the past were less dominant feature of interviews on Cathall compared to Keir Hardie. There is little sense of history. Even little attachment to Leytonstone was apparent. People may have liked the area once, but experience of Cathall may perhaps have diminished their good opinion of the surrounding area too. Its almost as if people wish to distance themselves from the past as well as the present. Although some of those interviewed (the elderly especially) were born and bred in the Leytonstone area, more residents had moved from elsewhere, usually other parts of East London. There is a general feeling amongst the elderly however that people used to be friendlier in the estate and the surrounding streets. People at a pensioners social club mentioned times when they used to have lots of visitors, and they miss the good shops which Leytonstone High Road was once provided with. A middle aged resident active in the tenants steering group was critical of the attitudes of some of the elderly: "a lot of elderly people use the phrase 'the good old days', when I listen to some of the people who come to the pensioners luncheon club, and I listen to how they had to suffer, with the poverty, with everything, then I wonder how good they were. ..But some of them have got very warped ideas. One man who came to the centre thinks that all foreigners should go back to their own country, yet he is a God fearing

man. ..It is surprising how many elderly people have got that attitude", (Doreen).

Accounts of people's initial impressions of the estate were sharply divided between those who had moved onto Cathall when it was still a reasonably desirable place to live, and those who moved onto it when it wasn't. Pat has lived on the estate with her husband and children since it was built 24 years ago, when she moved from nearby Leytonstone. Her comments are typical of the longer term residents; "It was like a palace when we moved here, everything was new, it's all changed now, it's dirtier...People were friendlier then, they are now more inclined to keep themselves to themselves", (Pat, 50).

Rapid population turnover meant that there were many residents interviewed on Cathall who had lived on the estate for less than 10 years. Newcomers on Keir Hardie were less common, and as we saw, had to work hard to be accepted into the community. On Cathall, in contrast, there was little 'community' to be accepted into. Four single parents who moved onto the estate during the 1980s, described their first impressions and early experiences. Their accounts focus on the poor reputation of the place, on isolation, distrust, and the depressing physical appearance of the estate, all features which are associated with their negative perceptions of the neighbourhood, and with somewhat restricted social interaction.

Jill has lived on the estate for 11 yrs; "It was frightening at first. I was used to living in a friendly house with friendly neighbours. Cathall was like a prison, no one seemed to know anyone, there was a very isolated feeling. The estate was built in 1962, yet people did not appear to be settled. Everyone seemed very unsure of themselves." This lack of community also had the effect of making it difficult for residents to find out basic information which they needed: " I didn't even know how to find a doctor ", (Jill, 30s). Elsa has lived on the estate for 9 years. She described the lack of trust between neighbours: "When I moved into this flat the neighbours did code knocking on the pipes. They watch to see if you are one of us. They were afraid that I might grass [about drugs] but they gradually realised that I was OK and seem to approve of me now". She seems to have reached a stage where being accepted means, not being included, but being ignored, rather than watched. She added "But I've never been invited into neighbours' houses. Two doors away a woman was burgled while she was away, but she never asked me anything about it, whether I'd seen anything. A combination of inaccessible housing and neighbours whose behaviour put them outside the law appear to be acting to exclude Elsa. As a black British woman she does not feel that she fits in: "They are mostly white on this floor with mixed race children. There are some Africans too, but they never talk to anyone."

For Lucy, it was the appearance of the place which she found most alarming : When I first moved to Cathall nine and a half years ago, it had a terrible reputation, worse than Chingford Hall. It was depressing, coming home to this grim grey mass", (Lucy, 32). For both Sofia and Mejabin, the experience of moving onto Cathall was totally negative. Sofia came to the estate with her husband and children in 1985 from the middle east. "It was a very bad estate. You had to be careful not to wear jewellery because of the muggings. I was very lonely, people were very reserved, it wasn't at all like the middle east where everybody was friendly. There, they got together for functions and helped each other ". Moving to the estate from Pakistan was a tremendous shock for Mejabin (26). She was from a middle class family and had been a teacher. "The flats here are very congested. In Pakistan the houses are big, light and airy." Her experience of living on the estate has made her afraid to go out. For those coming from a much worse situation, including people who are refugees from war torn countries, Cathall did not seem so bad. Issues of neighbourliness for example, may seem something of a luxury to refugees living on the estate. A Somalian woman said of her neighbours: "Nobody hurts me, they are OK, I don't ask for help", (Fadimah, 36).

However, newcomers have noticed some positive changes on the estate since they moved there. Jan, also a single parent, has lived on the estate for 9 years. She moved from Walthamstow, where she had been living with her parents, when she had her first baby. "It totally different from Walthamstow, its quiet there, here its noisy, with traffic, parties and noisy kids. But you get used to it and I keep myself to myself anyway...There's more community life here though now than when I first moved here ,there are more creches and playgroups, and I meet other mums there," (Jan, 29).

Attachment and cohesion

Are there elements of Willmott's "attachment community" on Cathall? To what extent is there attachment to people and to the place, to what extent do people interact with others and feel a sense of community, a sense of identity with place or group and solidarity with their fellows ? On Keir Hardie, factors emerging from interviews which were seen as key influences on neighbourhood perceptions included comparisons with other blocks, length and continuity of residence, housing styles and policies, age of residents, availability of social facilities and casual meeting places, large extended families living in the area, participation in formal and social organisations, and the experience of local work. Some of these have more salience on Cathall, and some less, and there are some additional, and important features which influence community life on Cathall.

Continuity of residence, as we have seen, is not generally a strong feature of the estate. Cathall was

built only 24 years ago. Some residents moved onto the estate from the surrounding Leytonstone/Leyton area (especially those who were longer term residents), but a more common pattern amongst those interviewed, was to move from another part of East London. Unlike people of earlier generations however, they were not moving into Leytonstone to go up in the world. Most of those interviewed would rather live elsewhere. For example: "I call this estate Alcatraz 2: easy to get on, difficult to get off. A lot of people set fire to their flats just to get off the estate," (Sonia). Sonia's son set fire to their former flat because he thought that his mother was unhappy there. It might be expected that the more elderly residents who had lived in the area for most of their lives, would, like their counterparts on Keir Hardie, be more committed to the estate than this resident and her son. However, at the beginning of the Cathall fieldwork, I visited a pensioners social club, and an old lady in her 80s told me that she'd lived in the district since she was four. I remarked that she must like it, to have stayed so long. She replied: "No I don't, it's horrible". Her remarks were to set the tone of many of the subsequent interviews.

Housing, it became clear on Keir Hardie, can have a crucial influence on the social relations of a neighbourhood. The links made by professionals and residents on the poor design of the old housing and the reputation of Cathall estate have already been discussed, as have the impact of 'dumping ground' allocation policies. Cathall residents were, in addition, highly critical of their housing, particularly in terms of its isolating effects. " Some people are isolated. The design of the housing makes a difference - the tower blocks are not as bad as the low rise, at least there are meeting places on the floors of the tower blocks. You can't really talk about neighbourliness in the low rise, because its difficult to know who your neighbours are ", (Don). Many find the numbering system of the flats bewildering: " I lived here for a year before I could find my way around here. I still find it difficult " (Lucy). The numbering system of the flats is indeed incomprehensible. Long term residents find it difficult, let alone visitors.

For the fortunate ones, moving into the new, HAT built terraced houses, has made an evident difference to patterns of neighbourliness: "The new houses have changed peoples attitudes. Now people have pride, not only in their homes, but in their estate. People in the new houses are being more neighbourly, are talking to each other." (Don). A conventional design, with streets and gardens, is clearly influential here, but there are other factors too, according to one resident: "Now that their horizons have changed they look to the future. You're not a second class citizen any more." While I was talking to Don some of his old neighbours invited him round, they had just moved into one of the new houses: "That's the first time they have invited me to their home, yet I've known them for 5 years" (Don).

As well as neighbourliness, perceptions of community have changed too. Barry's perceptions have changed dramatically, along with his change of housing. He hated living in the tower block, but is delighted with his new ground floor warden assisted home on the estate. In his old flat, he was constantly afraid of crime, but now feels that he can leave his back and front door open , without fear of burglars. His optimism is palpable, he'd been in his flat for only 13 days. Can the poor reputation of the estate and its lack of neighbourliness and general community spirit really be changed round along with the housing? Despite these positive indications, one resident thinks that's its too late to save the estate: " I don't think the new houses are a good idea. In 20 years' time it will be just another estate. They should buy more street properties and try to integrate them properly. What will happen in a few years time when the houses start to disintegrate a bit?. They are just basic, they have no character ". (Marie). [6]

The new housing may be a cause of jealousy amongst people living nearby. Helen lives in one of the quiet streets near the estate. She has a negative view of Cathall and the people living there. "Yesterday, I went for a walk with my husband and we saw the new council houses on the estate. All the new houses had cars in front of them so they don't need the houses, they can buy their own". (Helen, 24). I suspect that most of these were owned by people working on the estate. One of them was probably mine.

As we have seen, the old flats clearly do not encourage social interaction or foster integration, and most of the old shops on the estate are now boarded up, but there are other opportunities for meeting people casually, outside the local school for example, or in the adventure playground. Though valued by some residents, these don't suit everyone. Some do not like to talk outside the school, because they feel alienated from the other mothers, many of whom reportedly swear and shout, and not all parents are happy about sitting in the adventure playground, because : " the kids use foul language", (Pat, 29).

The HAT has built a smart new social centre, but it may not be meeting the needs of the average resident: "There's no where in the Epicentre where you can go for a coffee and a smoke. They don't cater for us, its just the voluntary organisations in there" (Sonia). There are pubs outside the

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6 The six HATs in Waltham Forest, Tower Hamlets, Stonebridge Park, Hull, Liverpool and Birmingham are spending up to £122,000 per family to rehouse them, much more than the cost of buying a local house on the open market, ('Cost,1997).

estate, in the Leytonstone High Road, but again, these do not suit everybody, especially Muslims: "For men, the local life revolves round the pub, but I don't go to pubs ", (Rashid). There is , however, a cafe just outside the estate. Some of the women meet there regularly. Sonia works in the cafe: "I've only got to know other parents since I've worked in the cafe...some of the mothers spend 2 hours in the cafe, laughing and joking", (Sonia). Meeting places like this are very important when the estate itself is so alienating. Residents on Keir Hardie, as we saw, spoke very positively about recognising people and being recognised when they went out. This kind of casual interaction, the weak ties in a network, played a very important role in helping to solidify positive perceptions of the community as well as for people's general sense of well being. As noted earlier, this does not appear to happen on Cathall.

Anti-social behaviour and crime

On Keir Hardie, residents identified differences in community enhancing behaviours between long term and elderly residents on the one hand, and new, younger residents on the other. Similar divisions were perceived on Cathall, but voiced in terms of those residents who had been there since the estate was built, and those "new people" who moved onto the estate in the 1980s. A striking difference between life on Keir Hardie and life on Cathall is that on the former, anti social behaviour is to a large extent confined to certain parts of the estate, while on Cathall, it appears to be much more widespread.

Several residents believed that the estate had changed for the worst as a result of the Council's policies: " Things started to change after about 10 years when problem families moved in. Then we started to get car theft, litter strewn around, then some didn't do their cleaning, now no one does. They employ cleaners now... People don't feel safe, and they are more inclined now to keep themselves to themselves", (Pat, 50).

Unlike the elderly living in one of the tower blocks on Keir Hardie where 'no one will get the chance to move from here unless it's in 6 bits of wood', (Bessie), opportunities for the elderly to move to more suitable accommodation do exist on Cathall. Some of the elderly living on the estate had been glad to move from the blocks which they shared with the newcomers. They now live in sheltered accommodation with similar long term estate residents. Ivy, for example was born in Leytonstone, and has lived in the area all of her life. "The flats in Cathall were lovely when they were first built, but then later all sorts moved in. There was swearing, drinking and fighting" ,(Ivy, 80). Madge lived in a tower Block on Cathall for 20 years, and is now living in sheltered housing just outside the estate: "I was glad to leave Cathall. It was lovely at first, our flat was gorgeous,

but all these new people coming in ruined it. There were muggings, and I got mugged once, and people wet in the lifts. I was frightened, living there" (Madge, 86).

Barry had always lived within 300 yds of where he was living now, in one of the new warden assisted flats. "Cathall was OK at first, a nice estate, apart from the lifts. It was nice until they started moving the homeless in from 1985. They wouldn't put their rubbish in the chutes, they threw it over the balconies instead, they still do", (Barry, 81). Barry's comments were confirmed by a professional working on the estate: "There used to be regular fires in the rubbish room, but they are cleaned now, and there were families who would throw rubbish - including dirty nappies- over the balconies". Bob too was born in Leytonstone. He and his wife used to live in a tower block on the estate but they asked the council to move them to the sheltered accommodation on Cathall: " If you have people above and below you who are respectable, and behave themselves, then its OK living here , but if they step out of line, its miserable. The coloured people had all night parties, they kept us awake all night. I told the council that I wanted to get out, and they were very good about it". ' New people', according to these accounts, refers to 'allsorts', young people, 'coloured people', the homeless and problem families. The elderly residents looked at their neighbours and saw a breakdown in cultural values, and were disinclined to mix with them. They may, alternatively, simply have been looking at difference. They appear to be much happier now that they are living near people they see as similar to themselves. As eighty nine year old Bob put it: "Life started when I moved here".

It isn't just the elderly however, or the longer term residents who object to anti-social forms of behaviour: Several of those interviewed who had moved onto the estate during the 1980s were very critical too. Elsa's comments were typical: "Its difficult to go out of the flats, the lifts were dirty, people spit and wee in them. I don't want to bring up children here", (Elsa, 25). Many of the young mothers- new people- had problems, but they weren't problem families. A middle aged resident, active in the tenants management committee, was highly critical of local housing policies: "They used to send problems families here, they were dumped here. Yet they shouldn't have been punished like this. A social worker said to me 15 or 16 years ago- they're a problem family, they don't deserve anything better than this estate. This was the attitude then of a lot of the professionals on estates, they saw them as dumping grounds", (Doreen). The process of "dumping" is, as Ann Power has described it, a process of allocating empty property in unpopular estates to anti-social or uncoping households. The numbers of such households on estates, according to Power, is usually quite small, but their impact is out of all proportion to their numbers, (Power,1994). Residents accounts on Cathall however, would seem to suggest that a process of stigmatisation spread to all

newcomers, with all the implications for community integration, cohesion and the development of social networks that might be expected. In any case numbers *may* well be significant here The community life of an estate would need to be pretty strong to withstand the apparently considerable movement of population onto the estate in the 1980s. On Cathall, it was not. Values are likely to break down when change is too overwhelming, an anomic neighbourhood is the result. On Keir Hardie, rapid and large scale unemployment has dented community life, on Cathall, too rapid a influx of residents , many of whom have problems, into an estate already unpopular, could well have scuppered it.

The fear of crime, and the experience of crime as victims or witnesses emerged as key aspects of life on Cathall amongst nearly all of those interviewed. Crime greatly influences people's perceptions of community on Cathall, and damaged social relations on the estate. Some residents talked about burglaries and graffiti, some complained about drug addicts, and dealing, and children finding syringes in the lifts. One mentioned a recent story in the press about a gang who terrorised a family living on the estate, and another about an 11 year old who was arrested for armed robbery, (Sonia). Some mentioned the seasonal nature of local crime: "It depends on the time of year. Coming up to Christmas- people do get mugged, homes do get broken into",(Doreen).

Some residents described their own experiences as the victims of crime: Bill is 89. He was mugged when living in Redwood Tower. "A man in the lift put his arm round my neck and elbowed me in the stomach, he pushed me, knocked my head against the wall. I had to have an operation for blood clots on my head ", (Bill, 89). Occasionally there is a racial element to crime, Asians, particularly Asian women, like the elderly, feel particularly threatened: "There is a lot of racial harassment on the estate. We've had fire bombs through the letter box. Two women on their own are an easy target ", (Nasreen, 22). Such experiences are damaging in a number of ways, they discourage people from interacting with others locally, harm their perceptions of the community, prompt them to move, and, as I will show later, harm their health. Mejabin, for example, according to her husband, " worries about going out alone, she feels threatened. Once a group of teenagers took her money and harassed her, " (Rashid). In Ameira's case, experience of crime had altered her perception of the area as a good community. She had been happy on the estate until gangs started causing trouble for a friend of hers, and when she herself suffered half a dozen break ins. "I have lived in Leytonstone all my life and wouldn't live anywhere else. There is a community spirit here, its just a few people who spoil it, like gangs ", (Ameira, 31). She has now moved off the estate. Christine's daughter witnessed a suicide. They changed blocks after this.

For those remaining, distrust and isolation can be the consequence " People don't feel safe now, people are more inclined to keep themselves to themselves too", (Pat, 50). A young woman living on a floor where drug dealing appeared to be taking place said "Neighbours smile, but that's all, they don't talk. Nobody trusts each other " (Elsa, 25). Rashid and Mejabin take avoiding action: "I like the tower block [on the edge of the estate] because you don't have to walk through the estate to get to the station or the shops. I have nothing to do with the rest of the estate", (Rashid).

Surprisingly, those in the new houses seem less concerned about crime now that they have moved. The boost to neighbourliness given by the new terraced housing- which itself promotes more positive perceptions of community- may be playing a role here. Jenny has been living in one of the new houses for 6 months. She likes her new neighbours: "the woman next door has 8 children, and she's only 30". However "when I lived in the old flat on Hollydown way I didn't want to get involved in the estate, I heard about the violence and the trouble, and my daughter saw a shooting, so I kept myself to myself". A not unexpected consequence of fear of crime and the diminished social interaction which it engenders, is that information is not circulated. Village gossip, of the kind still found on Keir Hardie, where "everyone has a tale to tell", just does not happen here to the same extent. As Jenny put it: "If something had happened on the estate, I would hear about it in the local paper, not from people on the estate ".

People on Cathall can be so alienated from one another that even immediate neighbours are not above suspicion of criminal activity. On Keir Hardie people were generally proud of their blocks and stuck by the people in them, but not on Cathall. "You don't know who you might be living near here, murderers, child molesters, they put them all here. Yet there are more children on this estate than anywhere else, it just isn't right ", (Sonia). Marie felt little attachment to her flat: "Where I live, there a group selling drugs, there's a lot of madness, and schizophrenia. When an 88 year old woman was murdered, the police knocked and wanted my neighbour for it. The man living there had been a known sex offender. I was very annoyed that we weren't told about this, I've got children. There are supposed to be 4 more sex offenders living on the estate. Its one of the reasons why I want to move... Not everybody is bad here, but they have put too many bad people on the estate ", (Marie, 32).

Francis, 31, a single parent, has lived on the estate for 7 years. All of her accounts of living on Cathall focus on the violent, disorganised side. A neighbour who'd been shot for squealing on dealers, a suicide, her bloke beaten up by three men. She is suspicious of her neighbours, and expects them to be up to no good. Francis is a very tough lady, who will readily lash out to settle

a dispute, but even she will not walk through the estate alone at night, because of an experience she had. Crowds of youths congregate on the estate from outside at night, and cause trouble.

The fear of crime, together with the estate's poor reputation, has acted to curtail the social networks of residents, not only by reducing contact with neighbours and other residents, but by damaging wider social relations as well. Some families refuse to visit: "I visit my family once a week, but my mother will not come over here. She is afraid of being mugged", (Jan, 29). Barry's sister lives in Leyton, but she would not visit him when he lived in the old tower block "because of all the Herberts hanging around the lifts. Its the drugs, you can smell the drugs as soon as you get near them. It happens at night time ", (Barry, 81). Sonia's brother won't visit her because he doesn't approve of her bringing up children on the estate. Elsa's mother will not visit either, and Marie's mother also refuses: "My mum won't come and visit me here, its the design of the place, the dark lifts, the horrible corridors, its so intimidating. You don't know who is going to jump out on you. Mum doesn't like the people here either, she says it is too rough". It is no wonder that those with the resources to do so leave. Marie plans to move to Essex, to make a new start. She and her husband want to bring up their children in a nice area. The estate, like similar ones in other parts of the country, is being depleted of 'respectable working class ' people like Marie and her husband, families with jobs and the 'traditional' moral values. It will be interesting to see if the HAT is able to halt the process.

Crime, or simply coping with a deprived and hostile environment, may also be acting to damage closer relationships too: "Nine out of ten people on this estate have relationships which don't last. There's too much tension and pressure " (Sonia). One of the first things that Jill noticed about the estate was that lots of people seemed to be having marital problems. Some, no doubt, will be 'chasing each other with hammers' as Jenny put it earlier.

It can be difficult to judge the extent to which the fear of crime, and distrust of neighbours, is justified. When I interviewed Elaine however, she was in a state of shock having witnessed an attempted murder the night before: "They pushed an African over the balcony last night. I've never been so frightened in my life. I went out onto the balcony at about 11 for my washing, I saw a man dangling from the balcony above, then they dropped him. He crashed onto the ground, there was blood everywhere. My friend on the next floor called an ambulance...That's why its so quiet this morning, the police are all around ", (Elaine, 30). Several people later mentioned this incident to me.

Ironically the incident did have the effect of getting people to talk. " Generally people round here are reluctant to talk, they don't seem to want to get close, but when that man was thrown from the balcony, people started to talk to each other ", (Rashid). Indeed on the morning following the incident - and before I spoke to Elaine - I saw people quietly talking in huddles, and wrongly assumed that community spirit was looking up on Cathall. The incident may have had the effect of drawing the community together temporarily, but for some residents, "the murder" as it came to be known, had the effect of increasing their fear and isolation. For example: " Mum has become phobic, she won't go out on her own, she's been mugged, and the incident of the man being dropped from the fifth floor has made her even more frightened ", (Nasreen, 22).

Participation in formal and informal organisations

The picture painted of Cathall so far appears gloom- laden, but there are many positive aspects to life on the estate. 'Community' in Cathall is more difficult to categorise in some ways than on Keir Hardie. On Keir Hardie community life was explored in its various forms in some depth. On Cathall, interview data puts questions of coping much more to the fore, not simply of coping with poverty, but coping with a stigmatised and dangerous neighbourhood. In these circumstances, people create community in different ways, through going on locally held courses, becoming involved in local projects, participating in tenant or self help organisations, or, as will be shown later, by disassociating themselves from the local community by participating elsewhere. To maintain a reasonable quality of life on Cathall , people have to be innovative, they cannot rely on the traditional and supportive structures evident on Keir Hardie. Services and initiatives help people to cope and help them to develop their social networks.

There are many opportunities for participation and involvement on Cathall. Childcare groups like Hollycats and Redwood Playgroup have been established for some time. Childcare was described by an active resident as "the cement of the community", (Don). A community development officer described some of the history of participation." People tend to come together over various problems, and to address change. People were concerned abut the lack of play space, lack of gardens for children from the beginning, and 16 or 17 years ago residents petitioned against the lack of a crossing to the school". There are longer term historic reasons why opportunities for participation are plentiful. " There was pressure in the last century for a community hall. It was built, along with the baths and washrooms in 1907. If an essential prerequisite for community activity is a place for it to be held, then that could account for the high levels of community activity historically ", (Community Development Officer). It is envisaged that the HAT's new community centre- the Epicentre- will act as a focus for involvement.

More recently, the need for re-development has galvanised local action . Local people fought for the HAT because they realised that the only way to get money for the estate was through the HAT. They marched to parliament and had the support of Waltham Forest Council and the local MPs. Once the Estate became a HAT estate, locals continued to be active. "Cathall people turned up at meetings and wouldn't allow the DOE and the HAT to walk all over them. They got some of the housing plans altered for example, and insisted that the childminders on the estate were consulted before new childcare schemes were set up ",(childcare worker).

Doreen and her fellow members of the Tenants Management Committee feel that they have gained much for their community by working collectively: " Without team work and the people involved across all four estates [HAT estates in Waltham Forest], we wouldn't have got were we were. We wouldn't have got what we got if we'd just sat back and then took what the DOE was offering us... We've had some dealing with people involved in the Hull and Liverpool HATs, they were absolutely amazed at what we've actually got from the Government. It's not been got lightly, we've had to fight for it and that had to be collectively, not just singly", (Doreen).

On Keir Hardie, both participating and non participating residents were attached to the neighbourhood. On Cathall the divisions are much sharper: those residents who are heavily involved in local activities and projects tend to be most committed to the area. Although Ameira, who runs a Koran group at the Epicentre, has recently moved to just outside the estate- she took the opportunity from the HAT to buy a street property- her commitment to both the place and the people was clear "I loved it when I worked there. I worked for the credit union and the Women's unit as an outreach worker". It was only experience of crime on the estate which prompted her to move.

Doreen is chair of the Tenants steering group, and has lived on the estate for 23 years. She is committed to Cathall, even if its a luke warm commitment compared to the attachment of many of the residents on Keir Hardie to their community: "Its not too bad, no worse than any other area, its had its ups and downs, but things have improved. Large estates like Cathall tend to get stigmatised by people that don't really know the area. There's a lot of good work that goes on. We've always had a good childcare network on the estate, and we've got more independent groups now- an elderly group, Koran Group, Somali Women's group and a Community Links which is mainly West Indian. They used to all keep themselves to themselves, but over the last few years, there been a lot of groundwork done to bring the groups together. The Summer Festival, for example, has a really

good feel about it, we re all here working in the same community, we want to do it better than what we had in the past". (Doreen). Interestingly, Doreen's attitudes to community, like those participating residents on Keir Hardie, but not to the non participating, are inclusive. Community is about more than people like herself.

Participation in the tenants group is not wide. Those involved in the HAT steering group are a relatively small minority of tenants: " We've gone through times when there's just been a mere handful of us, trying to get things up and running. Now that houses are being built, and people are moving in, its generating more enthusiasm. In the past, there have been many broken promises, and people get despondent. People have said that this re- development will run out of money and that phase 2 will never happen. When you get involved though, you find out for yourself, you get the right information, and you discover that yes, its going to happen but that it all takes time... I think that people are now realising that the opportunities are there to make changes and to voice your opinion" (Doreen). It was noted earlier that people on the estate are not informed about local life because alienating conditions encourage them to 'keep themselves to themselves'. Doreen's comments suggest that once people get involved, they become better informed and their hopes for the future are raised. This in itself is likely to have an impact on health, as well as their developing networks. Of course, one could imagine a scenario where the opposite happened. The woman on Keir Hardie for example who was told a new house was possible, only to have her hopes dashed , suffered depression as a consequence.

One resident involved in the tenants group approached the role in an innovative way. Francis was a member of the steering group for three years. She has not been incorporated into the HAT ideology, but has adopted subversive tactics: "I've had a few rows with people on the steering group. I'm for the tenants, I'm not for running up the HAT's backside. .. We all got to know each other through the steering group. It was brilliant at first, we used to meet up on Saturdays for a chat. But after 3 years, the HAT were taking over from the tenants. For some of them on the committee. It was oh yes Mr HAT man, we'll all come and lick your boots. But not me. I'm no longer on the steering group because I won't do what the HAT want me to do. I make a point of finding out what's going on from the HAT office, and when I get information, I pass it onto the tenants, if I hear any rumours I pass it on", (Francis, 31).

The issue of information is a key one here. According to one active resident: "The very poor are the last to find out about anything, and get involved ", (Jill). Nevertheless, as I noted earlier, it isn't simply being poor that leads to being uninformed. Impoverished social networks, a direct result of

alienating conditions on the estate, are part of the picture. Lack of knowledge is not of course the only reason why people do not participate in organisations. Many simply don't want to, some are wary. The vicar suggested that: "There is a suspicion of the Church here, and of the statutory agencies". General lack of trust between people on the estate may have a knock on effect, and influence attitudes to tenants groups. Sonia, for example, is suspicious of the steering group: "some have got new houses who recently moved onto the estate. No one knows how they voted on this new management committee. We don't know half of what we are supposed to have voted for on this estate ", (Sonia).

One or two professionals suggested that those who get involved are not representative of the estate. Yet of those I interviewed, the majority were like the chair, working class people with confidence and enthusiasm, only unrepresentative in the sense that they were active. Denny, as a young black single parent, is in some ways, fairly representative of people on the estate. She has been involved in running the credit union for 7 years. "There are 165 members, 80% of whom live on the estate. But it is difficult to get people involved. Those who are have a bit of spare cash, not the very poorest. It's difficult to get the ones who think they can't afford it to join". She thought that belonging to the credit union did improve members' quality of life and health. " Once people are involved, they come in here for a chat, make friends, become more confident and assertive. We've had a few people who joined feeling a bit low, when they come in for a chat it picks them up a bit. People are financially happier, they can ring up and say I've got a crisis, I need this money urgently. We don't want to know what it's for", (Denny, 30's). Unusually, Denny has had some success in getting neighbours to join. Not all will want to join self help groups of course, or are able to participate. For some, living on the estate may make it a less likely course of action. A disabled woman living outside the estate said " There are people with disabilities living in Cathall, but we at the Disability Resource Centre haven't been able to pick them up ".

The highly involved people described in the preceding paragraphs tended to have more commitment to people on the estate than other residents. On Keir Hardie, as we saw earlier, it was different. The majority of residents interviewed on Keir Hardie expressed sentiments which demonstrated that they were attached to the area and the people living there. Those residents interviewed on Cathall who did not express a high level of commitment to the area, were also less likely to be committed to the people in the area as well. The following comments are not untypical of people in this category.

"People on the estate aren't really go getters, they don't want the best for their families like people off the estate", (Marie, 32). "There is a bunch of gossips outside the school, always f ing and

blinding, they are really common, some of them are malicious", (Marie). "I was passing Mayville school one day when I heard a child say to its mother- "where's my fucking sweets you old c...I couldn't send my children there", (Lucy, 32). "We're going to have a new park nearby, and a cybercafe. Soon it will be an in place to live, but there will still be thick people, and badly behaved children", (Lucy). All of the negative aspects of the community described here are clearly having an impact on peoples perceptions of their fellow residents. It is not surprising that residents' local social networks are not developed. People living in the area surrounding the estate are much more positive about their neighbourhood and their neighbours. Helen, from Turkey, describes her road as " just like Coronation street, the neighbours are friendly ". Another adjacent resident felt positive about her street. "The black people and the white people talk to each other, there's no racism here, and there's no crime", (Asian woman).

One Cathall resident however, had learnt that people are far less alarming once you get to know them: "I've got to know more people since working in the cafe, including those I was too scared to speak to before in case they jump down your throat. But once you start talking to them, they are not what you thought they are" (Sonia ,40). With more opportunities to mix, people's perceptions of the area and the people could radically change.

Cathall can be viewed as a long term exercise in social engineering. 'Dumping ground' housing allocation policies were inflicted on some of the least pre-possessing and most socially isolating housing in the country. Community development and outreach work on the part of various agencies has done much to ameliorate the living conditions of some of those on the estate. Re-generation has been able to build on that base, and on tenant involvement. Power has pointed out that one of the continuing problems with highly marginalised estates is that their poor reputation often lives on despite improvements., (Power,1994). There is cause for optimism that a re-built Cathall will result in a rebuilt image. Many of the features and changes on Cathall are those considered by Power to be important for the success of area rescue programmes. They include: upgrading physical conditions; increasing community stability and reducing population loss by increasing the attractions of the area; involving the police in the community in local security; providing special support for the integration of minorities; encouraging activity such as shops, churches voluntary agencies, credit unions etc to create what Wilson refers to as buffers (Wilson, 1987). with the wider society; a long term community development worker; maximising the bridges between the area and the outside world, and involvement of schools, (Power,1994). In the long term we would expect to see strengthened social networks on Cathall, and better health as a result.

Not everyone wants to join things however. Some would just like a decent home, a job, and nice neighbours. Elsa described the sort of neighbourliness which she wished existed on the estate: " If we could all get along, it would be a better place to live. It would help our health, if we could all help one another, support our neighbours. It would be nice to be able to ask a neighbour in for a cup of tea, for a chat, or help someone financially or go on a picnic together, rather than come in an lock your door. Or we could babysit for each other. They don't do any of this on this floor. Neighbours smile, but that's all. People don't trust each other ", (Elsa, 25).

In any case , problems of poverty remain for residents, and there are indications that some will be worse off financially in their new homes than they were in the old. Higher rents are causing problems already, and the installation of water meters carries the potential for financial hardship as well as health risks.

Keir Hardie and Cathall each have elements of a health promoting community. Keir Hardie has the traditional aspects of a working class community, a history of local employment, stability of population, and neighbourliness. Cathall has plenty of activities to become involved in.

10. SOCIAL NETWORKS AND HEALTH OF CATHALL RESIDENTS

The sort of conditions on the estate which were described in the last chapter- alienating housing design, crime and fear of crime, anti social behaviour, population turnover, housing allocation policies- have made it difficult for people to develop local social networks and undermined any sense of community. Rather than neighbourliness there is distrust between residents, family strain rather than a local supportive extended family, anomie rather than strong local culture and values, alienation from rather than attachment to the community. However, plentiful opportunities for involvement in projects, self help groups tenants groups, as well as courses, toy libraries ad so on mean that there is a thriving positive community which co-exists with the demoralised community and has developed in parallel to it.

When social networks on Keir Hardie were examined, it was found that residents social networks formed certain patterns, and that these, to some extent reflected local conditions and the history of the area, as well as the individual's personal circumstances. The characteristics of the Cathall neighbourhood, are, as we have seen, very different from those on Keir Hardie. This chapter seeks to identify network types on Cathall. An aim is to consider the extent to which local conditions make a difference to residents' social networks, and by extension, to their health.

Interviews with residents, as with Keir Hardie, have been grouped together under network models. The networks models, as before, refer principally to the degree of similarity or dissimilarity in the network, estimated with reference to the range of membership groups which make up the network. Models will also refer to reference groups. As with Keir Hardie data, within models processes which affect health are explored. Links are examined between network models and structure, health protecting or damaging functions of networks, coping with poverty and deprivation, attitudes and values, and how these interact to affect health in particular circumstances..

It became evident in the last section that Cathall estate could not generally be described as a attachment community. As a consequence, the locality is a much less dominant aspect of many people's networks on Cathall than on Keir Hardie. Residents involved in tenants groups and voluntary organisations are an exception: as on Keir Hardie their networks can be loosely grouped as 'Networks of Solidarity'. For many of the remainder of those interviewed, social networks are either very restricted, or dispersed in some way. Social organisation on Cathall is more difficult to identify, patterns of residents' social networks are wide ranging, less easy to characterise according to the membership group typology adopted on Keir Hardie. They are individualistic, and personal. On Keir Hardie the Similar network model predominates, on Cathall, it does not exist in

its pure form, at least not amongst the sample of residents interviewed. Both estates have residents whose networks correspond to the Traditional model, but on Cathall, which has not been a work based community, and where community sentiments are less strong, it is a paler version. On both estates, residents in this category are a dying, or migrating, breed. On Keir Hardie models of social networks could, to an extent, be seen to reflect features of social class in a traditional working class area, where social organisation, despite evident changes, in some respects remained fairly static. On Cathall, the difficulty in grouping people into network models may be a reflection of a more fractured working class, itself a consequence, in part, of rapid social and economic change visited on the area.

The models: a typology

The network models which relate to the social networks of Cathall residents have been classified as certain types: *Restricted; Unsupportive family; Traditional;Relocating; Network of Solidarity, and Innovative.*

In summary, the individual components and attributes of each network are:

The Restricted Network

Membership groups: few
Structure: small numbers in network
Attributes: feelings of isolation, lack of self esteem, perceptions of low control. Few sources of support.
Health: poor
Attitudes: pessimism, lack of hope. Negative perceptions of the neighbourhood

Examples: newcomers; single parent and no local family; mother and daughter with no family in country and not employed; refugee; unemployed man with no family or other contacts; married woman with children and no family in country; carer

The Unsupportive Family Network

Membership groups: as 'Similar',relatively small number, made up of family and local friends
Structure: family not local
Attributes: support insufficient
Health: poor when overloaded
Attitudes: pessimism, political cynicism

Example: single parent

The Home-centred Network

Membership groups: as similar, relatively small number, made up of family and friends
Structure: few local contacts

Attributes: extremely negative view of community, positive perception of home
Negative reference groups: people on the estate
Health:poor
Attitudes: Conservative voter

Example: single parent

The Traditional network

Membership groups: consist of family, neighbours, Ex workmates, friends from social clubs or church
Structure: tight knit
Attributes: can rely on support, sense of belonging to sheltered accommodation and fellow residents, but no longer to estate as a whole
Attitudes: Labour party supporters. Value of coping
Health: they cope with it

Examples: elderly born, bred and in some cases worked locally, now living in sheltered accommodation Young woman with husband, 6 children and local extended family, used to work locally, church attender.

The relocating network

Shares characteristics of the Traditional network, but networks are established outside of the estate

Innovative networks

Examples: The Deviant response; the religious response

Network of Solidarity

Membership groups: wide range, consisting of similar and dissimilar groups
Reference groups: wide range of positive reference groups
Structure: both dense and loose
Attributes: good level of support and access to additional resources. Perceptions of self worth, esteem, feelings of control and identity
Health: good or improving
Attitudes: optimism, vision of hope for the future, social consciousness and tolerance

Examples: person with quite strong local ties of family or friends plus active in organisations or self help groups.

THE RESTRICTED NETWORK

A relatively high proportion of those interviewed on Cathall had networks which corresponded to this model of restricted membership groups, restricted numbers within those groups, and, in some cases, restricted reference groups, or had done so in the past. Though examples were similar to Keir Hardie residents, there were also some differences. For some newcomers for example, the restricted networks phase was more long lasting, and, in some cases, seemingly permanent. In

addition, some of the single people on Cathall in this model had many of the characteristics of those people on Keir Hardie who had violent or domineering partners. Feelings of lack of control, low self esteem, and lack of hope were evident for this group, as well as poor health. It was not however, a partner who was restricting their networks, but the alienating conditions on the estate, a well as their responses to them.

When Jill moved onto the estate she felt very isolated, and found it difficult to get to know people: " I found it like a prison...everyone seemed very unsure of themselves...I felt as if Id been put into a different universe, ...I suffered from a spate of depression at the time". Refugees can feel lonely and isolated wherever they settle. Mulki is a widow with 3 children. She moved to the estate from Somalia in 1991. She hasn't seen her family in Somalia for seven years and has very few contacts locally. Her husband died suddenly in 1994, this has led her to worry constantly about her own and her children's health. The children have asthma and one has kidney problems, Mulki herself has several health problems which started when she left Somalia, including skin, joint, eye and gynaecological conditions. There is one Somalian woman she can turn to for help in an emergency, but doesn't like to ask because this woman has poor health herself, and with 6 children, more than enough to cope with. Mulki's 's traumatised history is clearly more instrumental in harming her health than her pattern of social networks. However, such restricted social contact, or contacts who are lacking in resources themselves and unable to give support must exacerbate pre-existing health problems.

Nasreen is 22 and lives with her mother who is divorced. They are extreme examples of people living isolated lives. Nasreen has lived in the area for 17 years, yet she has few social contacts either on or off the estate, and no relatives in this country apart from her mother. She has lost touch with her school friends and has never worked. She had wanted to go to University but her mother became ill and she couldn't leave her. Nasreen's mother is very dependent on her, her daughter is her sole source of support. Her mother is wary of people, untrusting. As well as curtailing her social networks, distrust of neighbours, fear of the neighbourhood, may, in this case, be acting to restrict take up of services which could improve the quality of life as well.

> "I've been to social services , they say they can do tasks like shopping, but she really needs someone around, someone who she can trust. They can provide volunteer visitors , but you don't know who they are" (Nasreen).

Violent incidents on the estate, including the attempted murder described earlier, have exacerbated the older woman's fear and isolation: "Mother became even more afraid to go out after the incident of the man being dropped from the balcony".

Naseen realises that she herself is unhappy and isolated. She cries easily, and finds it difficult to concentrate. Her self esteem and confidence are very low. She believes that she has an innate inability to relate to people, yet she is articulate, intelligent, and warm. She realises that she has spent too much time with her mother, and too little with anyone else. Until very recently, when the Women's Project took her under their wing, there was no one she could go to for any kind of support or companionship for herself. I noted earlier in relation to Keir Hardie cases that research has indicted that single adults living with their parents tend to give more than they receive and that this increases their chances of early death, (Rogers,1996). Living on an estate like Cathall, where a lack of neighbourliness, lack of trust and fear of crime make it difficult to get to know others, or at least reduces the motivation to do so, will make ill health even more of a likely outcome than it might for someone in similar household circumstances on Keir Hardie.

For people like Nasreen and her mother, who arrived with already restricted networks, coming to Cathall appeared to make their situation worse. Others have found social interaction difficult too. Elsa is a 25 year old single parent with two young children. Although born in Walthamstow, she was fostered in Windsor until she was fifteen, when her Ghanian mother brought her back to East London. Life changed abruptly for Elsa:"In Windsor we were a very big family, with lots of friends. Here, mother objected to us having friends, this made me very withdrawn". Elsa has lived on the estate since 1987 but is still, nine years later, very isolated . "I don't know many people on the estate. I'm withdrawn, I don't like to approach someone unless they approach me". Her neighbours are in any case, as we saw earlier, unfriendly , untrusting, and excluding. She is not in contact with her mother "she used to hit us too much" Her sister is her sole source of support. She was happier when her partner lived with her, "at least there was someone to talk to". Yet Elsa is not a natural recluse, she is a very likable person, who, with a little support could be experiencing a much improved quality of life.

For those whose circumstances meant that their networks are already likely to be restricted , then the impact of the area where they live is particularly important. Lack of opportunity for casual interaction, fear of mixing with others, having difficult neighbours and so on, restricts their membership groups and (positive) reference groups, and increases their dependence on those few people they do interact with. Additional strains may be the result. As mentioned earlier, according to one resident 9 out of 10 people are reportedly having relationship difficulties, and according to another they may well move in happy, but soon will be 'chasing each other with hammers'.

Elsa's health is not good. She suffers from depression as well as physical ailments. The break up

of a relationship can affect anyone's health, but its effects are likely, as in the case of bereavement, to be particularly acute when networks are very restricted, with the inevitable dependance on the partner for companionship, support and so on which that entails: "When I split up, I didn't eat properly, my hair started falling out and I lost weight with the worry. I still don't eat healthily". Even the temporary severance of a close relationship had adverse effects in the case of another resident, Rashid. His comments illustrate the special significance of close relationships for health where there are no other sources of support and companionship:

> "I was very ill [with depression and raised blood pressure] when my wife went to see her family in Pakistan. When Immigration tried to stop my wife getting back my health got worse. I had no one to go to for help, I was very alone", (Rashid).

Elsa, like Rashid, would prefer to be in work: " My health was better when I was working, I could do what I wanted, I could go out. I was a lot more free and less depressed. I often visit the doctors now, for me or the children". Her comments indicate how poverty, personal circumstances and behaviour interlink to adversely affect health, including the health of children: " My daughter is a fussy eater. Maybe it's because she's unhappy, wondering what's going on, or maybe its because I'm not eating. I'm worried about her, and I've waited months for a hospital appointment for her". It was noted earlier that on Keir Hardie people with Traditional network models lay emphasis on eating well. It was also noted that food - buying it, cooking it, exchanging it- featured both in stories of mutual aid and in accounts of social and everyday activities. On both Cathall and Keir Hardie, food appeared to have less importance in people's lives amongst those with more restricted networks.

Elsa's health was particularly bad when her housing conditions were even more isolating than they are now, when she was living in a tower block on the estate: "I was lonely and really isolated, I wasn't used to looking after children. I didn't leave the flat much, because she [her daughter] took up so much time. It was difficult to get out of the flat anyway, the lifts are dirty, people spit and wee in them", (Elsa).

Policy interventions, in providing help, in providing opportunities for involvement, are a potential lifeline for people in this group. Once Hollycats (a community development child care project) found Jill, for example, and she became involved, then she became a different person. Mulki is receiving help from the Educational Visitor, and is attending English classes where she is beginning to meet others. Nasreen's isolation cannot be reversed overnight, but the Cathall and Avenue Women's project have recently been very supportive to her. She has started to work one day a week at the project. It has given her something to look forward to and she is feeling less depressed. She

is still very unsure of herself though, afraid of picking up the phone, and ashamed of herself for getting upset easily. Her self esteem is still so low that she does not feel justified in her behaviour, believing that other people have far greater problems than her and yet they cope. However, involvement in the project, in providing structure to her week, proving support,and reducing her isolation, as well as the chance to learn and to work, will be likely to gradually improve her esteem and health along with it. Elsa is trying to meet people on the estate. She enjoyed a visit to the toy library, because she was "made to feel welcome." Elsa would desperately like to live a normal life, with a job, a nice home and nice neighbours. Her present way of living is not natural to her- her attitudes to others makes that plain. Her reference groups are open

Like Nasreen and her mother, Mejabin and her husband Rashid lead severely isolated lives. Their only membership groups are their nuclear family, and Nabeela's family in Pakistan. Organisations and initiatives, have not, as yet, managed to draw them in. Mejabin came to this country to marry, her husband has lived here for some time but was made redundant 3 years ago. Neither have relatives in this country. They have been unable to make social contacts on Cathall: "I've been here 9 years but it was several years before anyone spoke to me", (Rashid). They feel frightened and intimidated by the estate and the people living on it and avoid walking through it as much as they can. Rashid is unemployed and his health is very poor. His health is improving with medical help but he believes that a job would improve his health and well being enormously:

> "Trying to come to terms with unemployment is difficult. When I worked [he was a cashier] I was part of normal life, part of society, in the mainstream, doing something for my family. Its very important for morale" (Rashid).

The effects of unemployment , as Rashid's case shows, can be particular severe when social networks are so restricted. In his case, restriction was influenced by personal family circumstances, but perhaps more so by living on an estate where social disintegration is its most dominant characteristic.

Not all isolation locally is attributable to living on Cathall. People living outside the estate can have restricted networks too, especially if they are unemployed, but interviews (though limited) suggest that it is far less likely, simply because the streets of terraced housing are neighbourly and residential patterns are more stable. John (64) however, who lives in one of the quiet streets near the estate, is unusual. John is a carer. He gave up his job in vehicle repair so that he could look after his wife who has MS. He knew "hundreds of people" when he worked, but does not keep in touch with his old workmates, because "all they talk about is work, and I miss it so much". Again, the effects of unemployment, are in his case, and like Rashid's, worsened by his restricted social

networks. John's only source of emotional support is his daughter, whom he sees regularly. Community nurses can visit his wife to help, but he feels that their visits entail a loss of his independence."I can't wait in all day for community nurses".

When Mejabin was younger, and living in Pakistan (she is only 26 now), she was very fit and full of energy. She worked as a teacher, had a nice home with her family, and lived a full life. Now she suffers from headaches, backaches, and depression. She is also however, very reluctant to consult a doctor. "I don't look after myself, don't eat enough food, or get enough rest. My little girl is too attached to me. I just cook and clean. Id like more variety in life". Chronic dependence of children on their mothers is a characteristic, as noted earlier , of women attending Newpin on Keir Hardie. They are usually referred to Newpin because of relationship difficulties with partners, and with children. Violence is a frequent undercurrent. Yet this is not the case with Mejabin. She and her husband are gentle people, whose relationship with each other and their children appears to be good. What they share with the Newpin women however, are networks which can offer them little support, and minimal integration into the local community. The combined effects of immigration- of leaving her family behind in Pakistan- of poverty, of living in a tower block with young children, and of living on a deprived and alienating estate where both she and her husband seek to avoid contact with others, are clearly having a seriously detrimental effect on this young woman's health. Indeed, what is striking about all of the residents' accounts in the 'Restricted' group (John excluded, he is not so hard up materially) is the combined effects of material and social deprivation on their health.

These effects are more clearly evident when the processes involved are considered. Perceptions of lack of control, like their Keir Hardie counterparts, is a dominant characteristic of people with restricted networks, as is a lack of hope. Rashid feels powerless and helpless, and like several residents interviewed on Keir Hardie, links his personal lack of control with his reasons for not participating in initiatives or organisations to change things. He would like to see changes in this country- especially to the NHS but feels powerless to play a part in change himself:

> "I don't have the power to straighten out my own life so how can I do other things. I feel helpless, I don't belong to any group, party, or pressure group, I'm a passive person. I will vote Labour though, for public services and the common person. ...I want to lead a normal life, and look after my family. But its not under my control, when you can't do it the depression and the illness creeps in. I feel tired, very lethargic, dizzy, and I have pains. I hate living on benefits, I try to sign on at a time when no-one will see me." (Rashid)

John sees his life as dictated by his wife's requirements. If he is ill, he puts his wife into respite care: "Before I can go into hospital myself I have to make arrangements for her. It annoys me, I

have to plan my life around my wife when I am ill". His emotional life varies with how his wife treats him, and he is a little bitter about the situation of gender role reversal he finds himself in. "I'm not in control of my life, my wife is. Its not like other couples where the man is in control of his life," He has had serious health problems himself during the last couple of years, including chest and eye problems. He has little hope for the future, he can only see his situation getting worse. Elsa does not feel in control of her life either, in her case,because she is poor, and lack of money dictates how she conducts her life:

> "I would like to go out to work, but can't, its not worth it financially. The system is in control of my life, I wait for Tuesdays, then shop, then put so much for rent, electricity etc. Any little mistake you make, and you can be in trouble, you can't eat. If my little girl doesn't like the food I give her then she goes hungry. I go without to make sure they are OK. I don't go to the pictures, or have meals out. I don't buy the food I used to buy, I cant afford it. " (Elsa)

Like all of those in this group (except John) there is no-one to help out financially.

People with restricted networks are usually so overwhelmed with their own problems that they have little energy to comment on the national picture. They don't see this a fair country however. Elsa for example thinks that benefits are going to the wrong people, like bogus asylum seekers and people with partners. She would like the money to be given to the homeless She would like the Government to get rid of all of the estates, "they look like prisons", and believes that the Government should help mothers go back to work by providing care facilities- a point mentioned by several of the single parents on the estate. "If you have to pay a childminder £60 a week you have nothing left. She is disinterested in politics, and doesn't vote "it doesn't make any difference".

Positive reference groups for this group are few. Negative reference groups are the anti-social and criminal element on the estate. Understandably, none feel proud to be from Cathall. Their commitment to the estate is negligible.

Life experiences and health

Residents talked about times when life was good and not so good, and about the sort of things which they themselves believed influence peoples health in general, as well as their own health. For some in this group, the good times were in another place, at another time, in Somalia before the war, in Pakistan when young, or simply, when employed. For those who had aggressive parents, they were in another part of England when fostered as a child, or in Eastbourne when evacuated as a child. One resident linked an expanded social network to happier times. For Nasreen, whose usual contacts were restricted to her mother, a visit from an uncle who came over from Pakistan to visit had given her life a tremendous, if temporary boost : "He gave me something to do, a routine to

work round". Not surprisingly, Cathall estate did not feature in residents' accounts of better times. Relationships, particular their severance through break up with partners, or bereavement, were mentioned in connection with the bad times of life. Even temporary severance of a relationship- when a partner goes abroad to visit relatives for example- are linked with very unhappy episodes. Residents link these life events with their own deteriorating health. In one case bereavement understandably worsened pre-existing insecurity. "After I lost my husband, I worry too much about the children. I worry about my own health. Who will look after them when I die?" (Mulki, 36).

Ideas on health determinants were influenced by their own experiences. They all, in their various ways, seemed acutely aware that their restricted social networks played a major role, though the processes involved were seen differently by different people. As we saw earlier, a majority of residents interviewed, across all network models, linked poor health with living on the estate. Isolation, hostility, crime, were all seen as leading to stress and depression. In many cases, these seemed more important than making ends meet. On Keir Hardie, on the other hand as we saw earlier, although environmental issues, particularly pollution, were mentioned in this context, the estate and its people on the whole were seen in positive terms, and not viewed as a health hazard in the way that Cathall was. Elsa added some everyday examples of how she believed living on the estate could affect peoples health: "Here, there's a lot of noise, music, drills in the flats, it can drive you mad. People can make you unhappy. If you have bad neighbours, or are rude to you, that affects your health".

Elsa believes a number of circumstances affect our health: "being lonely, not going to work or getting the qualifications you need. These things all affect people's health. No one was born to burgle, or be a rapist, or to be mental, it all depends on what happens to you, and how your life turns out". As we saw earlier, several linked lack of control to their own poor health- the fault of the system, shortage of money, a spouse, not being able to work. John, surprisingly perhaps for a Lib Dem voter, put it down to class. "Its class that affects your health. If you come from a powerful family you can get a job, and you can pay for health care". John's father, (deceased) must have influenced him. He was a member of the Communist Party and was there in Cable Street.

Those who had worked in the past, like Elsa, Rashid and John said that their health had been much better when working. The effects of the experience of unemployment on health were clearly recognised by Rashid: "Since being made redundant I have suffered from depression and my blood pressure went through the roof.... If I can get a job I can contribute to society. Even when working

it was difficult to make ends meet, but it is important for your own morale that you work", (Rashid). The benefits of work in his case concerned the opportunity to contribute to a wider purpose, and enhanced self esteem.

Some saw isolation as a threat to health. For Nasreen, who leads a desperately isolated life, companionship is inseparable from health status: "If you're happy, it helps your health, and having people around you, that makes a lot of difference to your health. I'm an only child though", (Nasreen,22). Others mentioned the role of emotional support. Rashid for example believed that had he been living in more favourable circumstances- in a different area or had more support- his health would not have deteriorated so much: " I can positively say, if I'd had someone to lean on, someone to talk to, to console, it would not have gone this far. I needed morale support, someone who is there, basically, I was totally alone...if the doctor had tried to get me help sooner, like a counsellor, it would have stopped the slide", (Rashid).

One resident in describing what she thought would be good for health, was, in a sense making direct links between people seeing something in common with others, in having more positive reference groups, and better health for those around them: "I don't like to segregate people, black and white, we are all the same. If we could all get along, it would be a better place to live. It would help our health, if we could all help each other, and support our neighbours", (Elsa). Unusually for this group, Elsa's positive reference groups are clearly wider than her actual membership groups. She is not as desperate to leave the estate as many of the others. With a little more encouragement she could be leading a very different life.

One of the features of this group for both estates, is the importance of the quality of relationships for health when networks are restricted. People in this group are likely to be very dependent on the individuals in their networks for their needs. They stand in contrast to many of those in the Pluralistic and Solidarity group on Keir Hardie for example, for whom being single was a positive state. A high proportion of single parents live on Cathall estate, some of whom will have restricted social networks. Jenny, a single parent herself, described the plight of the many single parents on the estate. They have multiple problems including lack of money, lack of emotional and practical support, but their major problems thinks Jenny, stem from their relationships with men:

> "Men don't want to give up their freedom or their money, they may resent the child, but may still want to keep the woman on if other relationship doesn't work out. So they may have another baby, and hope he will stay this time. But young men these days don't want to take on responsibility, they are selfish, want free sex, jewellery, flash cars. They see

> single parents as easy because we have a need to be loved. So most of us hope that it will work out this time. But the man goes, or just comes back for sex, and the woman gets depressed. The mothers get blamed but they are just looking for love. They would like to work, but child minding costs a lot. The Government think we have just one child after another, but we really want it to work. Single parents have told me that they have had partners living with them who have brought another girlfriend back with them to the flat, their children know that their father is in the next room with another woman. The self esteem of these women is so low that they want a man even on these terms. Some men deliberately go out and look for single parents. They are nice to her at first then they take her money and beat her up." (Jenny)

Jenny added that the health of many single parents on the estate is poor, in particular, "they are depressed, but hide it well."

THE UNSUPPORTIVE FAMILY NETWORK

The Similar network, as we saw, was a dominant network on Keir Hardie. The network was based on strong tight-knit local ties of similar people, particularly family ties. One of its characteristics was strong positive perceptions of the local community. There were no residents amongst those interviewed on Cathall whose networks could be classified as 'Similar', at least in the localised sense. The proximate extended family, for example, is not, unlike Keir Hardie, a strong feature of the estate, and fewer residents were born and bred in the area. The apparant paucity of residents on Cathall whose networks correspond to the 'Similar' model, may be an indication, not that this is a traditional working class community, like Keir Hardie, which is less strong than it was, but that it is a working class community which no longer exists. The contrast between the two estates confirms the relationship between perceptions of the area held by residents, and the degree to which they mix with fellow residents.

The next two cases however bear some resemblance to the 'Similar ' model, in the sense that they are based on a relatively small number of membership groups made of people like themselves. The first I have called the 'Unsupportive Family Network', and the second, the 'Home Centred Network' The neighbourhood does not feature strongly in the networks of these two cases, especially the latter. In the first, the family are neither local or supportive, in the second, interaction with local people is minimal.

Jan (29) is a single parent. The structure and characteristics of her network correspond in many ways to those of the single parents on Keir Hardie in the Similar group. She tends to mix with single parents like herself, and has one good friend on the estate. Her family live in the same borough- Walthamstow- but she cannot rely on them for support: "Mum doesn't agree with anything I do. Every time I'm pregnant (she has 3 mixed race children) she moans. She's like that,

she says haven't you got enough, it upsets me". The white single parents in the Similar group on Keir Hardie tended to have very restricted reference groups and like their mothers, racist attitudes, Jan however, does not share these attitudes with her own mother. She visits her family once a week, but, as we saw earlier, they won't visit her here. Her mother is afraid of being mugged.

Jan gets little support from her mother:"She doesn't come over to help me, my friends help me more". Like a couple of the elderly people in the traditional group on Keir Hardie, Jan co-operates with her friend over Sunday dinners, they take turns to do it. People in the Similar net model can be particularly reliant on their family. However, when support is not forthcoming- as appears to be the case for Jan, then the individual will have to cope alone. Jan finds it difficult to manage financially, even with a little cleaning job on the side. Bills are difficult to cope with, and buying things for the children, particularly trainers, a common pattern in interviews on Keir Hardie, was for the Grandmother to buy the trainers. [1] Jan does not try to access help from other sources. She is not a joiner, and although she goes to the toy library, finds it boring. "All they talk about is the price of nappies".

Jan's unsupportive network took its toll on her health at a time when she was in most need of it.. Her health was not good during each pregnancy:

> "I had blood pressure with all three, I was in and out of hospital. With the last one, I went into hospital to have the baby, and came out the same day. They didn't ask me if I wanted to stay, but I had no one living with me to help. a friend took the other two children, and I had them back the next day. I got depressed after that one, I cried every day for 6 months. I was anaemic and tired . He had cholic as well. None of the mothers offered to put him in a pushchair and walk about with him. People look at you as if to say 'why can't you stop him crying'. Mum didn't help, her view was, you've had the baby, now its down to you."(Jan 29)
> Jan's then partner did not help either.

Jan's attitudes to life and politics, are, like her counterparts in the similar group on Keir Hardie both realistic and pessimistic. She doesn't think that this country is fair to people in her situation: "You can't get anywhere. If you've got money, you can go far". She doesn't expect things to improve in the country, because "there are too many bad things going on which affect children, like drugs". She doesn't vote " it doesn't matter who gets in, it wont make a difference." Jan would like to go back to work however - she used to be a bacon packer- but adds "If I did so now it wouldn't be worth it financially". She needs encouragement and support to find part time work, a change in the benefit rules so that more of her earnings would be disregarded, and affordable child care. She is

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[1] Graham has noted that grandmothers generally are very helpful, and provide gifts (Graham, 1993)

not demoralised and depressed like many of those in the Restricted group, she's a resourceful woman who just needs a little help. If she were living in a more neighbourly environment she would probably be able to build up adequate supportive networks to make life easier, and protect her health. A job however, is probably a more feasible alternative.

Life was good for Jan when she was at school, and when she worked as a bacon packer in Walthamstow.. The last couple of years have been not so good. Interestingly, she believes that being depressed affects our health because we change our behaviour at such times. "If you're depressed, you smoke more, and drink more coffee". Understandably, she believed that the family can have an effect on health: "You can't choose your family. When they are down they can make you even downer".

THE HOME CENTRED NETWORK

Lucy (32) is a single parent with 2 children living in one of the new houses. She has lived on the estate for nine and a half years. She has a relatively small number of membership groups, consisting of people like herself - family (mother, sister) two local friends, and a small number of positive reference groups. These characteristics would place her in the Similar network model. However, unlike her counterparts on Keir Hardie, the local arena plays little part in her life. Instead, she distances herself from the neighbourhood as much as she can. Lucy feels that she has little in common with most of those living on the estate. She finds them "common and thick". To cope with deprived conditions on the estate, with anti social people living there, and indeed with her own poverty, as well as an unhappy childhood, she turns inwards, focusing all of her attention on her home. To protect her children from badly behaved children on the estate, she takes them, not to the local school, but to another in Leytonstone, where there are fewer children from estates "and not many single parent families".

Lucy is on income support, and runs a catalogue.[2] She explained: "I got myself into debt, catalogues are life savers. To manage, I sometimes go without food." Appearances are clearly very important to her - having the right furniture (the same suite as a character on TV for example), new clothes- not second hand- for herself and her children, collecting her income support from the Post Office at 8.30 in the morning so that no one sees her. Lucy takes a great deal of pride in her new home - it is elegantly furnished -and does not consider herself poor. She would be insulted to be

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[2] Graham has noted that mail order catalogues are the most common form of consumer credit among low income households, especially for white women with children. (Graham, 1993)

called poor. Yet she and the children have never had a holiday. Lucy is permanently stressed about money, she worries about debts in particular. Getting into debt via catalogues may be a coping mechanism for Lucy, but it comes with a price. The constant struggle to keep up appearances seems to have had an effect on her physical health also: "My health is poor. I've got quite bad bronchial asthma, I've been on steroids, and I'm on 3 inhalers a day".

A fairly narrow range of positive reference groups, and attitudes of 'looking after your own' were common in the 'Similar' group on Keir Hardie. Unlike those residents however, Lucy's positive reference groups do not include people on the estate, nor do they include single parents like her self, or the poor. Voting Conservative reflects her wish to identify with better off people. Unlike residents on Keir Hardie, she has little sense of personal identity, little sense of belonging. The alienation from others like herself has to be worked at, it makes her anxious, and could well be having an adverse effect on her health.

THE TRADITIONAL NETWORK

This network model includes membership groups made up of family, neighbours, ex workmates, old school friends, and friends from social clubs and church. The structure is tight knit. Five elderly people, with ages ranging from 81- 101, were interviewed in this category. With one exception, a woman born in Bethnal Green, they were born in Leytonstone, were ex manual workers- though in a more diverse range of occupations and localities than Keir Hardie residents- had quite strong (by Cathall standards) local friendship networks, and were regular attenders (apart from the very elderly lady) of social clubs. One woman explained why the pensioners social club was important to her: "It takes you out of yourself. If you are happy, its good for your health." (Ivy 80) One man Bob (89) had found a new lease of life through giving talks about his wartime experience as a firefighter. Friends and family give support when its needed to those in this group, as can the wardens of their flats.

There were many similarities between these elderly people and their Keir Hardie counterparts. Like them, these residents lay great stress on being active, on working hard and never being idle, on maintaining their independence and on coping with life. Keeping out of debt was also important. They tend to be Labour voters, and have a good opinion of the local MP, whose help they enlisted when the HAT built over a pathway to the main sheltered accommodation block. Bob met Donald Soper on the Jarrow march. Barry described his own political attitudes: "I've always worked for a living. I always voted labour. I am a Labour man. I would vote labour even if I won the lottery". Most of those interviewed would like to see more work, and better schools for Britain

in the future.

Despite these similarities with their Keir Hardie counterparts, there was one important difference: attitudes to their neighbourhood. As we saw earlier, they had all managed to escape what to them were appalling conditions on the estate by moving into one of three sheltered housing developments, two of which were on the estate, and one just outside.

Although the majority of those on the Keir Hardie estate whose networks fell into the Traditional model were elderly,. there were also some younger people whose networks corresponded to this model. They had dense knit localised networks, experience of local work, and had participated in social clubs and so on. Similarly, there are younger people in Cathall whose networks correspond to this traditional group. They are however, a dying or emigrating breed. For those remaining, life can be hard. Elaine is only 30, she lives in the old flats with her husband and 6 children, one of whom has cerebral palsy. She has lived in the area for 14 years. She met her husband very locally - at the chute.

In some cases, social networks may seem adequate by normal standards, but may be inadequate to meet needs where these are great. Despite being part of a large and fairly localised extended family, Elaine appears to give more support than she receives. "Sometimes I look after my sisters' children, they don't look after mine because I worry about the children if they are not with me. She has local friends from the estate as well as friends from Walthamstow where she went to school, but, with so many children, doesn't have a lot of time for socialising. She has recently become a regular churchgoer, and has met a lot of people through the church, where she does a Saturday club for children. "Since joining the church my life has changed, I go out more, meet more people. Before I used to just stay in and look after the children and knock myself out. I enjoy just going and talking to God. I don't go to parties, I leave that to my husband".

She used to work in an old peoples home, "but the doctor said I was run down, and had high blood pressure. I used to worry about the old people". She misses it: "I still go there to visit them...their eyes light up when I take my children with me". Elaine is looking for a full time job because she cannot manage on her income. Her husband, a painter and decorator, doesn't earn much. "Paying bills is a problem..I go without things, sometimes I don't eat for 2 or 3 days, I just have toast. I make sure the kids eat though. I can't remember the last time I bought myself anything, it must have been 5 or 6 years ago".

Elaine's health is not good. " Now I've got sickle cell trace, [she is West Indian] I've had it for a

year. I get run down, and am short of breath. I can't do what I did before - I used to be a keep fit addict. The doctor sometimes phones to see if I am alright". Like residents on both estates whose lives are pressurised, she smokes to help her deal with stress. It is unlikely that Elaine's health, because she has so many commitments, would improve if she took a full time job, though a part time one, if it eased her financial situation and gave her more social contacts, might.[3] Low wage earning families like Elaine's (people who used to be referred to as the 'respectable poor') need help so that they are not financially penalised if they take on part time work.

THE RELOCATING NETWORK

Apart from Elaine, an example of someone with traditional networks who was in difficulties, there were additional people on Cathall, who, if living on Keir Hardie, might very well have fallen into the 'Traditional ' group. However, their dislike of current day conditions and life on Cathall meant that they had little attachment to the place or to many of the people living on the estate. In response to local conditions, resourceful residents in both of the following examples are setting up social networks *outside* the estate. Cathall estate is a hostile environment for the Traditional working class. Yet class is generally very much bound up with area of residence; a traditional working class area, like South Canning Town, as noted earlier, tended to be inward looking. In these two Cathall examples, people's networks are expanding outwards physically, they are less locality bound. Their responses to social deprivation and disintegration on Cathall are individualistic. In contrast, the group with networks which correspond to 'Networks of Solidarity' and which are examined later, respond collectively to improve conditions locally.

Pat (50) has lived with her husband on the estate since it was built 27 years ago. She works as a childminder, and enjoys the job very much. All of the childminders on the estate know each other; it is a densely knit group. However, most of the children she now looks after are not from the estate. Her positive reference groups do not include locals. When she takes the children to school she now feels alienated from the young mothers there. "These are people I feel distance from. They are coarse and shout and swear at their children, and hit them on the way to school. You hear conversations like 'If that teacher touches you I'll be straight in there'. Im glad that I don't have any young children now". Her grown up daughters live in nearby Leyton and Walthamstow, but for other social contacts , Pat is now distancing herself from an estate she no longer feels part of. She has set up friendship networks in a village in Essex.

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[3] Part- time jobs have been shown to benefit the health of working class women in particular, but not full time. (Bartley,et al,1992)

> "I know a lot of people in that village through my sister in law, they've done fundraising and built a village hall, we've helped with that. We go to dances there. If I could move there I would really feel at home. I can relate to the people there."

Pat and her husband may not be able to afford to follow the traditional migratory route from East London out to Essex, but for them, they are doing the next best thing. Pat's's health is very good. "I don't have time to be ill." She keeps fit and eats healthily.

Marie(32) lives with her Ghanaian husband and children. Marie is also a childminder, and like Pat, the children she looks after do not live on the estate. Her networks locally are tightly knit, she will see lots of people on an average day- her sister, local friends, people from weight watchers. Her mother will not visit her on the estate however. Her greatest source of mutual support is a friend who lives on the estate. Although a very friendly and outgoing person "I will mix with all kinds, I just have to like the person, you can learn from different people", she does distance herself from many of those living on the estate. "People who gossip, they're the only people I keep my distance from. There's a bunch of them outside the school, always f...ing and blinding, they are really common, some of them are malicious." Rather than take her children to the local school, she takes them to one some distance away, in Stratford. "People think I'm stuck up because I take my children to a Catholic school in Stratford" (she isn't), and at weekends she takes the children well away, to the seaside for example. Both Marie, and Lucy- who we looked at earlier- are responding to limited social networks in an anomic neighbourhood by segregating their children from the surrounding neighbourhood and forming networks elsewhere. Sonia, also mentioned earlier, responded in a similar manner. She refused to allow her children to play out on the estate and went without herself so that she could take them to dancing and swimming lessons elsewhere. Marie and her husband (who works in vehicle repair), do not plan to stay however. They are saving hard and hope to move to Essex to "give the children a better start".[4]

Like their Keir Hardie 'Traditional' group counterparts, both Pat and Marie subscribe to the old traditional values of hard work, thrift, and getting on with life and coping. On the morning I met Marie, she had been up at 5 o'clock in the morning. "Nan always said, don't waste your life in bed".

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4 Marie, Sonia and Lucy in the last section, are responding in a similar way to some residents on 'The Projects' a highly disadvantaged neighbourhood in Philadelphia. Furstenberg et al's ethnographic study looked at conditions that promoted a successful response to disadvantaged circumstances. In the Projects, like Cathall, there was very little social interaction among neighbours, and people expressed a desire to move. Resourceful parents on the Projects segregate their children from the surrounding community, and form networks elsewhere. Limited social networks and scarce services in anomic neighbourhoods were found to compel many families to seek sources of support outside their community (Furstenburg,1993)

On making ends meet: "Things have been hard in the past, but you can always manage to put something aside. I don't drink or smoke, so its easier than it is for some. You have to be resourceful, you have to be hard, you have to just get on with it".

Marie's attitudes to health reflect her attitude to life in general. Her health is excellent. She puts this down to doing half an hour's exercise a day, to keeping active, and not giving in to problems. "Living here , and the attitudes of my family to my living here, have not affected my health. You can say yes- it is depressing and get depressed, or you can make the best of it". She has little sympathy with those who do not cope: "You can have emotional problems, or you can be tough, and get on with it. My sister has an easy life, yet she can't cope, she lets her problems get her down". One way of 'making the best of it', for Marie, is to hope and plan for something better: " You can want something better, you can have some hope. We hope to move out to Essex", (Marie). She is following a familiar and well trodden path. It will be interesting to see if the HAT regeneration is able to slow the exodus of traditional working class people like Marie, people with traditional values, people who used to be the backbone of the community, who contributed to making a neighbourhood socially cohesive. In a sense it is particular detrimental to the Cathall neighbourhood that someone like Marie has no motivation to stay. Unlike many in the 'Traditional' group on Keir Hardie and Cathall, Marie's attitudes are not insular, and her positive reference groups are open. She is a white woman married to a black man, her best friend on the estate is black.

Marie and Elaine's political attitudes are similar to those of the elderly Traditional group already described. Neither think that Britain is fair: "Its hard for those without money, and its hard for the middle classes"(Marie) . "they keep letting people in, and they keep putting up prices, food prices, and TV licenses. Its hard for us families to manage", (Elaine). Marie's reference to the 'middle classes' is interesting here. Older Traditional Canning Towners or people who live on Cathall tend not to mention the middle classes as a reference group. Both would like to see some changes " I don't know much about politics, but if someone is sick, they should be able to go to hospital and be treated. Money shouldn't be discussed even. Although there is more poverty in this country, there are still rich people. What are they doing with all that money? I vote Labour. When I look at John Major I see someone who is a school caretaker- he never admits that he has done anything wrong". (Marie). Elaine would"like to see them getting rid of flats, and giving houses to all families with kids. I'd like to see better schools, and better facilities for single parents. I was in that category - a single parent, and it was hard for me".

Life experiences and attitudes to health

The good times for the group of elderly people whose networks corresponded to the 'Traditional were various. For one, it was when they were children: "when we hadn't got much money but we were happy. Children weren't so ill mannered then, now you see little ones playing in the playground at 9 o'clock at night, their mothers don't have time for them" (Ivy,80). For Madge, like one of the elderly women on Keir Hardie in this group, it was the war, and the chance to broaden her social networks: "I was an attendant on the ambulances. I saw terrible things, but I was happy though. You met a nice class of person [Madge is the only Conservative voter in the group] they were good times", (Madge 86). They were not good times for Bob however: "The war was not a happy time, it was horrible, but I met a lot of good men. I was a fireman in London, my nerves were at breaking point, you were always on duty. I had to pull out little children, dead, from the bomb damage near the docks in Silvertown",(Bob). One of the most memorable moments in Bob's life was meeting Donald Soper on the Jarrow march. The best time in Doris's life was "when I was 80 and went over the Niagara Falls", (Doris 101)

There have been bad times of course, but people in this group were proud that they coped with them. For example:"I've never been downhearted. Even when my husband died, when he was 40, I had to carry on for the kids", (Ivy 80).

Attitudes to health for Cathall residents with Traditional and Relocating Traditional networks are similar to those found amongst the Traditional group on Keir Hardie. Values of hard work, keeping active and coping are carried over into attitudes towards health. Ivy, for example, put her good health down to work: "When I was younger my health was fine. I put it down to doing two jobs, I did a catering job at night then went to work for the co-op in the morning. I loved it. It kept me healthy, I didn't have time to mope and think. I've been fit most of my life. It wasn't until I packed in work that I got anything wrong with me", (Ivy 80). For Bob it was sport which helped him to cope with his nerves which were damaged by his experiences in the war. He coped by adopting health promoting behaviour, rather than by relying on drink or tranquillisers. It paid off, Bill is still here, and still active at 89. His health, although previously good, is less so now. He has been knocked down twice recently by bicycles on the estate! Madge puts her good health down to "being a good organiser, and a good mixer". Eating well is also seen as important for health by people in this group . The oldest resident interviewed said: "Until 3 months ago I cooked all me own dinners", (Doris101). She misses her recently lost independence now that she can no longer do so.

The attitudes of those with Relocating Traditional networks are little different. Again the approach to health, as we have seen, reflects attitudes to life: there's an emphasis on keeping active, hard work, thrift, and getting on with it. When negative life events strike, they cope: "When I split up from Laura's Dad (her first partner) I bounced back, I wasn't going to let him see that I was upset", (Marie).

Pat, like many on both estates, believes that poverty leads to stress and depression. She also had some interesting thoughts on the benefits to health associated with work and the social contacts associated with work. She focused in particular on self esteem: " It's important that we are liked, and that the jobs that we are doing are important...you need to feel good about yourself for good health, you need to be appreciated work wise. It gives you confidence". The health giving benefits of work have already been explored for people on both estates, but particularly for Keir Hardie, where local work was such a dominant feature of the community in the past. What is interesting about Pat's comment however, is that she sees similar benefits to work, as residents on both estates - and whose networks correspond to the Solidarity model- say they derive from participation in organisations and initiatives. Involvement, and gains made in self esteem, is a kind of substitute work.

NETWORKS OF SOLIDARITY

Residents whose networks correspond to this model have , as on Keir Hardie, a relatively wide range of membership groups, consisting of both similar and dissimilar people, and many positive reference groups. The structure is both dense and loose. They are more committed to their community, Cathall estate (or Leytonstone) and the people living there than Cathall residents considered so far. An example is the person who has spent many years in the area, has strong ties of family and or friends and who is active in voluntary organisations or other groups. As we saw earlier, opportunities for involvement on the estate are relatively plentiful. Compared to Keir Hardie, where continuity of residence is a strong feature of the estate , fewer were born and bred in Leytonstone. Their mixed membership groups confer a range of health protecting benefits.

Ameira, Denny and Jill are typical examples. Ameira is 31 and lives with her husband and three children. Her husband works nights as a display assistant. She has lived in Leytonstone all her life and wouldn't live anywhere else. She recently took the opportunity offered by the HAT to buy a street property bordering onto the estate. She works part time in an after school club in a nearby estate, and is heavily involved in local initiatives. She runs a Koran group, and used to work for the credit union, and the Women's project as an outreach worker. Denny is a black woman in her 30s,

and lives with her two children and unemployed partner. She has lived on the estate for 12 years. She has been involved in running the credit union for 7 years, does advocacy work, voluntarily, for people with mental health problems, and is currently doing a first aid course on the estate, and an access course for a social work course at college. She goes to church every Sunday in Dagenham, where she was born. Jill is a single parent in her 30s who has recently moved into a street property after living on the estate for 11 years. Jill is involved in the HAT steering group and has been involved in other organisations.

Ameira's proximate extended family live in Leytonstone, and she has local friends on the estate and off. Her friends know her family, but not her workmates. She has lots of local contacts : "My children don't want to go shopping with me, because I stop and talk to everyone." Denny's membership groups include her immediate family, her family in North London, her partners family in Leytonstone, her church friends, voluntary organisation friends, and course friends. People in this network can usually rely, like their Keir Hardie counterparts, on a great deal of support from the people in their network. Ameira's family help her automatically with the children, and she can go to friends for financial and emotional support. Although Jill's father, a stevedore on the docks, died when she was 14, her current boyfriend is supportive, as is her mother, and Jill has friends all over London. Denny can contact her partners parents in Leytonstone if ill or if she needs help with the children. She doesn't have someone close she can go to for emotional support but finds a great deal of comfort and solace from just going to church and praying. She adds "Going to church makes you strong, you don't take things out on the kids, you feel a real person, you feel that they care. Church has given me the strength to carry on with the credit union, in spite of problems, in spite of people distrusting you ", (Denny).

They enjoy involvement in organisations, and gain from it. Since being involved in various activities, Ameira reports that she has grown in confidence, become more independent, and got to know many more people. Jill's involvement has really opened up her networks:

> "Things changed when the HAT took over, it was brilliant. I've been on TV, met Michael Howard, and I dressed up as a tower block for the Prince Charles Exhibition at the V and A He talked about Cathall as part of his vision for re-development. Charles is wonderful. He listens to you and asks questions"(Jill).

Jill has gained in self confidence since involvement, and in knowledge too: "I like to come away from meetings feeling that I've learnt something". Information as an added resource is an important benefit, not available to the same extent to people in other models on Cathall. People whose networks correspond to the solidarity model tend to have quite strong perceptions of personal

control. Although Jill feels that she will never be totally in control of her life while she is on social security, she nevertheless does have access to information, and that is empowering in itself: "Social security controls a lot of peoples' lives on the quiet. Yet I know what I'm entitled to." This last remark is important.. Some of those with different network models, such as people with 'Similar' networks on Keir Hardie for example, did not appear to know what they were entitled to.

Most of the residents in this group are in good heath, although they have not always been in the past. Ameira puts her excellent health down to being happy and positive; the only time she was ill was when her mother died. At that time she developed boils and suffered from depression. Problems she experienced on the estate - gangs of boys breaking in and causing trouble- did not affect her health. She seems to be able to withstand a certain amount of stressful life events, not in the traditional way of 'getting on with it, but because she has access to a wide range of support, information and advice, and outlets for her energies. Similarly she was able to withstand the nuisance and break- in problems on the estate, at least in the sense that her health did not suffer. As well as protective networks Ameira and her husband have material resources not available to all on the estate. They are in work, they can do something about problems, in their case, buy a house just outside the estate at a discount. The close correlation between material and social deprivation noted earlier in the Restricted group, is parallelled in Ameira's case by a correlation between relative material and social advantage. This is not the case, however, for others in this group, whose rich networks co-exist with their own material poverty.

On both estates we have seen examples of residents whose experiences in a earlier phase of their lives have implications for their current health status and patterns of social networks. Both Denny and Don have been able to some extent to surmount a legacy of childhood problems through local involvement. Denny's emotional health has not been good however since she has had relationship problems, and a nephew, who she was close to, died. Her childhood was very unhappy and disadvantaged, with "an evil stepfather" for example. Yet she has achieved a lot, for herself and others since she arrived in Cathall from Bed and Breakfast. Denny is a example of someone who, with the right opportunities, can overcome a very disadvantaged childhood and early life. However, she would like to achieve more, and considering the amount she does for the community, particularly through the credit union, deserves to. Like Val on the Keir Hardie estate, she feels a little bitter sometimes: "people like me are not paid and if I did work, it would be low paid, sweeping floors or something".

Don's (36) unusual background and lifestyle make his networks difficult to classify. His open

reference groups and membership groups, his dedication to others place him in the solidarity network model. He is the only resident interviewed who went to University. Don is on invalidity benefit. He describes himself as psychologically disturbed. He had a very unhappy childhood: "My mother rejected me as a child, much of the time I felt isolated...My childhood was vicious and malicious, I suffered from psychological and sexual abuse ". Don is heavily involved in a range of tenants and voluntary organisations on the estate. His reference groups are wide. "All people are important to me. My life is completely tied up with the community. My purpose is to serve". He believes that his commitment is helping him to repair his damaged health: "Giving is helping me to find my sense of self worth, its helping me to move beyond my past...Childhood left me with a poor sense of self worth, consequently I didn't take care of my body". He does now, and his physical health is better. He believes also that "love is important, making people strong is important", (Don,36)

Though Celia, (39) does not have local roots, she is an example of how a network of solidarity can be created, by herself, and by others supporting her. A poultry farmer when she lived in Ghana, she moved to Cathall with her daughter when her husband was killed by the Ghanaian government. Despite "not having a family to protect her", and despite suffering abuse from fellow Ghanaians on the estate, Celia has become very active locally. She has received support from a number of local organisations, including the Cathall and Avenue Womens' Project, the Church, Victim Support, as well as the Educational Visitor. They have also put her in touch with outside organisations, such as the Medical Foundation for Victims of torture. People have written to the Home Office on her behalf, the Women's project helped her to move, and she receives lots of emotional support from them: "They have made me feel loved",(Celia).

Celia is now on the management committee of the Women's project. Involvement has given her more confidence, and courage to face the future. She finds time to do voluntary work on a Christian kitchen van which feeds the homeless in Walthamstow and Leytonstone. She is clear about what she gains from involvement "Being active helps me to stop thinking about the past. When I started this kind of work I realised that there are people with worse problems than me. That built up my courage". Celia's reference groups are clearly broadening. She has adopted an old lady (via age concern) and takes her to church.

Her terrible experiences- including the death of her husband and son- have left a legacy on her health. She is still on anti depressants, though her health is improving, and her uncertain future vis a vis the Home Office has not helped. Celia phoned two weeks after I interviewed her to say that

the Home office had granted her request to stay.

In contrast to Celia, Doreen (48) has lived on the estate for a long time, for 23 years. She lives with her husband (a cleaner for the HAT) son, daughter and grandchild in one of the new houses. She works part time as family group leader and runs a luncheon club for the elderly, just off the estate. She is probably the most heavily involved local activist on the estate. She has been involved in the HAT steering group for seven years and has been chair for the last three.

For support she can turn to her family, but also to the members of the steering group "Its really like an extended family in many ways, and , like families, you do get disagreements, but we sort it out". Like Jill, she's learnt a lot from her involvement with the HAT

> "We've had training from the HAT, its good. I never would have thought before that I would have been chair of the estate steering committee, but I am",(Doreen).

There's nothing parochial or insular about her networks. Through involvement on the HAT she has got to know a range of people she would not normally have been in contact with, including DOE officials, tenants groups from other parts of the country and in Europe, and groups based on minority cultures. Her positive reference groups are growing along with her membership groups: " Obviously there are groups that you tend to be a little bit wary of, but when you get to know and understand their cultures, that tends to go, you find that they are working not just for their own people but for the community as a whole",(Doreen).

Two adjacent residents have networks which loosely correspond with the solidarity model..Not in the localised sense however, their attachment is to an interest group and their families are of the dispersed kind. Both have disabilities - arthritis- and are involved in a self help group, and both are of West Indian origin.

Lena is 54 and lives with her unemployed husband. They live in a terraced house near the estate, and used to be very happy there but plan to move because they are tired of the disruption caused by the building of the M11 link road extension. Lena's membership groups are quite diverse: her family, her extended family in the West Indies, neighbours, friends, church people, and fellow members of the Disability Resource Centre are amongst them. Some of these groups are interconnected, some are not. Mollie (60) lives across the road from the estate, in an attractive ground floor property. Mollie has a wide range of membership groups, children in America, local friends, old friends from work, her church, and various disability groups. Her networks consist of separate groups but they occasionally overlap,.

They both gain from their activities. Like some of the other residents we've considered, Louise's faith and involvement in the church helps her to cope with the stress associated with lack of money experienced since both she and her husband became unemployed. Involvement with the Disability Resource Centre helps Lena to cope with her health problems, and importantly does much to confirm a positive self image. The ability to mix with people she sees as similar to herself has clear health benefits: "It's helped me to stop feeling sorry for myself. It's like a family, everyone helps one another. We are all people with a disability. It gives you a sense of it being alright".

For a woman confined to a wheelchair, Mollie is extraordinarily energetic. She belongs to several disability groups, and serves on a number of committees. This work has brought her into contact with a wide range of people, including local MPs. She is very well informed, and feels fearless in bargaining for her care and services. She says that she is certainly in control of her life, and links feeling empowered with the knowledge she has gained. Mollie is very confident. She appears to be good at organising friends, neighbours and family to help her in emergencies. She has a good relationship with her doctor, including telephone access. Of course, it is possible that Mollie possessed many of these attributes before she became heavily involved. She was also a nurse, which puts her into a different social class grouping from the unskilled or those on the estate who have never worked. And, of course, she does not live on the estate. However, she herself believes that she has developed along with her increasing activities, and she is better able to cope with her disability. The comments of both Lena and Mollie suggest that self help groups in particular, and the mutual aid involved, help them to cope with their disabilities. As we saw earlier in the case of Vilma, a woman on Keir Hardie, a self help group helped her cope with a very demanding life, and protected her health. Their networks indicate a health promoting balance between altruism and egoism. Some of those Cathall residents whose networks fall into the Solidarity group, as on Keir Hardie, may veer slightly towards an excess of altruism. Denny, for example, may fall into this category: at times she seems to be doing far more for others than others do for her.

Attitudes and reference groups

It was noted earlier that Keir Hardie residents whose networks corresponded to this model were motivated by perceptions of inequality. Their Cathall counterparts do not differ in this respect. All of the residents in this group would like to see a fairer, more equal society. They dislike class distinctions, greed, and the stigmatisation of the unemployed. Lena for example: "There's one rule for the rich and one for the poor, and there's discrimination between black and white, on both sides. Everyone should be treated the same, everyone treated equally, young or old, rich or poor, black or

white". And Denny "...people look down on you because you're out of work",(Denny). Mary has strong views on what is needed to improve Britain- "more money for the health service; it was much better when I worked for it; get people back to work. Beveridge 5 great evils are still here today". Denny would like to see more money where its needed- in health, schools and employment Jill learnt about inequality the hard way:

> "Britain isn't fair, so many have untold amount of money, so many are poor. I did a week as a homeless person once, I wanted to see what it was like. I got so fed up at the time, so depressed, people treated me like scum, as a lesser person. Some made advances towards me for prostitution... My health suffered of course, I was starving, and caught bronchitis" (Jill).

These experiences have influenced her desire to be active: " That's why I want to help people...I must help the people round here first, before I can help anyone else."

As well having hopes for the future, and wanting to achieve change, they see a role for themselves in making it happen. Mollie believes in lobbying and talking to people, "including people like you" to achieve results. She has had contact with one of the local MPs. Jill sees a role for herself in making change. "We've changed things for the better here, but there is only so much you can do, (Jill). Doreen is committed to the benefits of working collectively , " in partnership with others" to achieve change, but realises that it can't be done overnight: " We've had new members elected onto the redevelopment groups and they think they can come along like knights in shining armour and solve the problems immediately, but you can't, its a long slow process. It does call for patience and understanding" (Doreen)

Their positive reference groups are wide : "I see everyone as a human being, I mix with all different kinds of people", (Denny). Ameira sees many as like herself: "I have white and West Indian friends as well as Asian friends", and as for others she "would like to see a change in people's attitudes, more understanding of each others' cultures." (a point echoed by several in this group). " People are frightened of the unknown. I don't see people as different colours, nor do I see them as how many legs they've got. I've got friends in wheelchairs", (Jill). The propensity to see others like oneself, to have wide reference groups, is , in some cases, likely to have preceded involvement. There is almost a direct link here, at least in Don's account above, between seeing a wide range of people like oneself, and wanting to help them. There are indications however, as we saw on Keir Hardie, that participating can foster it. For example: " The credit union brings me in touch with all different races and religions " (Denny). Doreen would like to see Britain in the future

> "...working in harmony. I can't see it happening though, a lot of it is to do with people being ignorant of different cultures, and being intolerant of others. *That's something a lot of us have learned, tolerance",* (Doreen).

I noted when considering Keir Hardie residents in this group that most , although poor, were living in good, or reasonably good accommodation, such as terraces or ground floor flats. This is also true for most in this group on Cathall (Debbie is the exception, she is in an old flat) However, Cathall residents like Doreen, Jill and Ameira were also active when living in the old flats, so conclusions cannot be drawn here about any association between type of housing and involvement.

Life experiences and attitudes to health

For some of those interweaved, the good times are now. Despite unhappy childhoods for some, they are active and fulfilled. One resident, Don, made explicit links between his present involvement and regaining a sense of health- protecting self- worth denied to him in his childhood. There may be similar causal pathways to better health for people like Denny, who similarly had an unhappy childhood.

Additional unhappy times for some included moving onto the estate, but, active involvement in the community had deepened their commitment to Cathall. Bereavement, as expected, was mentioned by several as amongst the worst times in their lives. For Ameira, however, life has always been good, apart from the time her mother died. Armena's network structure, her involvement in the community, the good level of support she can rely on from family and friends, seems to enable her to withstand a certain amount of stressful life events. When gangs were causing trouble for her and a friend on the estate, this did not (as such things do for others) cause her so much anxiety that her health was affected. Bereavement did however. For some, the good times included marriage, for one, divorce. One account of better times was quite different to those heard on Keir Hardie: "Things were better in the 1960s. There was more of a community spirit amongst Afro-Caribbean people. People from the same West Indian village would visit each other in London", (Lena).

Attitudes to health determinants were similar to those espoused by Keir Hardie residents in the Solidarity group. Bad health was associated with stressful life events, for example "stress can trigger things like arthritis, in my case, when my husband died and I had to bring up my children on my own", (Mollie). Good health was described as variously attributable to being active and positive; giving to the community and thereby finding self worth; having a supportive family, and gaining strength from religion. Jill's ideas were typical: "I've got good health because I keep active. As soon as you start thinking about problems you get depressed, if you are low you are more likely to get a virus. Getting on with life and having a laugh is what is important...I never get bored, I love mixing with people", (Jill). Doreen added a very perceptive comment. She thought that active involvement can give those with unhappy backgrounds a reason for living.

INNOVATIVE NETWORKS

For a small minority of individuals, their networks and lifestyles are so unusual that it is difficult, inappropriate to classify them by the criteria adopted here of membership groups/ reference groups, and network structure. What is significant here, is the innovative responses they have adopted to deprivation. It is how they cope which is significant, how they cope with poverty , with living in a deprived and stigmatised area, and, in some cases, with the legacy of an unhappy childhood or earlier phase of their life as well.

Two cases are described here: Francis and Jenny. Both are single parents, both in their early 30s and have had troubled lives. Their responses however, couldn't be more different.

Francis (31), is a violent, angry woman. She describes her own life in terms of violent incidents. She gets what she wants in life by deviant, subversive, sometimes violent means. She has lived on the estate for 7 years, before which she lived in various B and Bs and a tower block in Leyton, 18 floors up, where she was very depressed. "To get this flat I phoned 24 hours a day and 7 days a week". Her abusive behaviour seems to have paid off : "I said to the woman on the phone 'if I was a wog or a paki I'd get a place just like that'. She said 'I'm a Paki'; I said 'that's your fucking fault.' Next day I got a place, it just shows you".

Francis's childhood (in Hackney) was unhappy, her mother kept leaving home, and her Father threw her out when she was 16. Her family are not supportive, but her friends- mainly men- are. She likes having a boyfriend around, but resents the loss of control which this entails. For financial support "I'd rather borrow a fiver off friends than ask Mum and Dad. We're all in the same boat, we're all on income support and unemployment benefit". Her social networks are difficult to identify, and appear to consist of a shifting , changing collection of people. Francis was involved in the HAT steering group for 3 years, but did not become incorporated into the HAT ideology; instead, she subverted it. She likes to feel in control of a situation. She also admires others who stand up to the system: "I was really angry about the M11 especially the way the police treated protestors. I admire the old girl who stood up to them, she's amazing",(Francis).

A fighter in all senses, and this is reflected in her range of reference groups. Francis is anti the police, doctors, her parents, politicians, the HAT, ethnic minorities, and many women. She is for- her friends- mostly men, other tenants, and the poor and homeless. She is cynical about the political system "Who can you trust? The Conservatives? They are only interested in making the rich richer and the poor poorer. Labour? They are more interested in gays and lesbians and ethnic minorities.

The Lib Dems? I haven't a bloody clue what they're for... The Chancellor [in the previous administration] does my brain in for putting 15p on fags and taking 27 p off whiskey. He needs shooting". The only public figure she mentioned to escape her censure was Prince Charles. He impressed her when he visited Cathall estate.

Francis 's health, like her life, has been up and down. She has suffered from bronchitis in the past, from migraines, and from arthritis in the hands. She puts this down to the times when she would thump the wall in anger, rather than lashing out at the kids or anyone else. She connects her past episodes of bad health to a spell in hospital when she was a child of five. It has left her hostile to doctors and to her parents. She had a fight with another child in the hospital, so they strapped her down in the cot, and transferred her to another hospital, without informing her parents. She felt totally abandoned and isolated.

Francis fights against ill health, as everything else. "I don't want to whinge like my mother". She links ill health to lack of money, to stress and to poor housing. Yet for her, stress is necessary, "Doctors can't give me the money to lead a stress free life. Anyway, I couldn't live with a stress free life. If things are on the level for too long, I get bored", (Francis,31).

Jenny, (33) the second case in the Innovative group is a black single parent with 4 children. Her mother, who has paranoid schizophrenia lives with her. Jenny had a very unhappy childhood, and tried to commit suicide when she was 11. Jenny has turned to religion to help her cope with her problems.

Both Francis and Jenny are hard up. In Francis's case, money prevents her sometimes from becoming involved in things.

> "My main worries are money and the kids. If I can't feed the kids, I don't take notice of anything else going on around me. I have to sort out my problems first, I dropped out of the homes project because of money worries ".

Jenny described some of the problems involved in living on income support: "We 're not allowed to earn more than £15 per week before our benefit are affected, its not enough." Living on Cathall can make a tight financial situation even worse. Relationships characterised by suspicion and lack of trust between neighbours add to a mother's problems and can have an effect on children's and mothers'health. Jenny explained:

> "It's difficult to manage, but if your child doesn't look smart someone might call the social services in, and say the child is being neglected. So if you buy winter shoes for the child, you may have to go without food".

Fortunately, Jenny can rely on help. She is a keen churchgoer. The church people give her a great deal of support. "I used to find it difficult to make ends meet, but the church people are very good, if they see you need something, they offer it." Her religion has helped Judith in less tangible ways too. Its given her the strength to cope with splitting up with her partner, and to cope with looking after her mentally ill mother. She's a joyful person in spite of her many problems- her mothers acute bouts of illness, the discovery that one daughter had been abused, two of her children beaten up by police, the legacy of an unhappy childhood. She used to be very depressed, but since going to church, she has been able to be calm in distressing circumstances. The church has also given her back some of the esteem she lost as a child, when she was abandoned and suffered from abuse. In addition, "...the church has helped my physical health too, because I've stopped drinking and my asthma has improved " (Jenny).

Coping

A common theme has been how people cope with life, poverty and health. It was suggested in the chapter on Keir Hardie that residents respond to poverty by adopting certain coping mechanisms, and that these vary to some extent according to the type of social networks. There were similarities on the estates between how people in certain network models- Restricted, Traditional, and Network of Solidarity- were able to cope.. There were also differences overall between the two estates however. As on Keir Hardie, Cathall residents talked about coping with poverty, but on Cathall they were more likely (amongst those interviewed) to talk about coping with a deprived, stigmatised and socially disintegrating estate. The sort of conditions on the estate which were described in the last section- lack of neighbourliness, alienating housing design, crime and fear of crime, anti social behaviour, engender distrust between residents and make it difficult for people to develop local networks. For some, coping simply involved coping with not being able to lead the sort of ordinary/traditional life on the estate which they would have liked to lead.

To cope, people need to be innovative on Cathall, they cannot rely so much on traditional structures of family and neighbours- especially the latter- as they do on Keir Hardie. The networks simply don't work as well as on Keir Hardie, where community life is much stronger. On Cathall there were innovatory coping mechanisms evident. As we have seen, they included disassociating oneself from the estate, and becoming involved with people outside the estate, by, for example, avoiding walking through it, taking children to schools outside the area, paying for children's leisure activities outside the estate and discouraging them from playing on the estate; and establishing friendship networks in a totally different location. Some of these things were done at no small

personal cost. One individual turned inwards "retreated" to use Merton's term, from the neighbourhood, though not from society at large, by keeping up appearances in the home. This can lead to debt, anxiety and ill health. One individual coped by subverting the system, and adopting aggressive and sometime violent tactics.

On both estates people turned to religion and church/mosque membership, but amongst those interviewed on Cathall it appeared to be more of a vital coping strategy than on Keir Hardie Participating in local voluntary organisations and services and self help groups occurred on both estates, and such activity was instrumental in developing social networks and improving the quality of people's lives. Hoping for something better was also an evident coping strategy. For some individuals on each estate whose networks corresponded to the 'Network of Solidarity' this might mean a more equal society, a more harmonious one. For others, particularly on Cathall, it could involve hoping for a new house on the estate, or moving away from the area. For those whose resources did not permit such coping mechanisms, the results could be isolation, depression, fear, disputes with neighbours, despair, feeling powerless, feeling so overwhelmed with problems that you give up, and poor health. As we have seen, the more restricted the membership groups in the social network, the more this is likely to occur.

11. CONCLUSIONS

"...fellowship is life, and lack of fellowship is death..."

William Morris., *A Dream of John Ball.* Reeves and Turner, 1888.Reprinted from the *Commonweal.*

This research has demonstrated that social networks mediate both socio-economic position and health, and place and health. It confirms that class matters for health, for women as well as men. The effects on health of class linked poverty and deprivation are clear from the structural analysis of the LeaValley region. The qualitative research on two housing estates on East London confirms that being poor can affect health in indirect as well as direct ways such as those connected with income and living conditions. Having low self esteem, feeling powerless, fatalistic and unable to cope are the most important of these. It also confirms that being poor can lead to social, as well as material deprivation; it can limit the potential of health protecting benefits derived from social networks. It also demonstrates however that these various effects are not universal. Different patterns of social networks are evident on the two deprived estates under consideration and these can mediate poverty and health in different ways. The relationship between class, poverty and social networks is not straightforward. Place matters for health also, but so do attitudes and values.

Poverty and health in East London

The structural analysis of Lea Valley boroughs confirms known relationships between class, poverty, deprivation, and health. Causal factors implicated in determinants of health inequalities- poor housing conditions and overcrowding, unemployment, and low incomes- are dominant characteristics of the region. On a range of individual and composite deprivation indices, boroughs in the Lea Valley are the most deprived in England. On almost all the measures available, official statistics and Health Authority reports demonstrate that health in the four boroughs examined - Tower Hamlets, Hackney, Newham and Waltham Forest (the southern half at least)- is very poor. Mortality rates are high, and amongst the younger sections of the population are a particular cause for concern, as are perinatal and infant mortality rates. Morbidity indicators include high rates of Long Term Limiting Illness and hospital admission and emergency admission rates for both physical and mental illness. Both admission rates and mortality rates are particularly high in the most deprived wards in the area. On several measures, East London boroughs are the worst in London, a reflection, in no small part, of the socio-economic profile of the area.

Comparison of deprivation indicators over time demonstrated a significant increase in poverty and deprivation in the Lea Valley area between the early 1980s and early 1990s. There is evidence that

health indicators are worsening locally as well. Mortality rates for local boroughs have worsened, and especially in the most deprived wards. Raised Jarman scores indicate high levels of health needs in the most deprived areas. Published survey evidence suggest that health services do not match high levels of need in the poorest parts, health services, in this part of London at least , are not over-provided. Some innovative health services which encompass a 'social model' of health, and which aim to encourage participation in health services and the community are encouraging, but may founder due to inadequate funds.

The suggestion in sections of the health literature that London is in something of an anomalous position was investigated. Published analyses of mortality and other statistics have observed better health chances for London residents during the 1980s compared to people living in similarly deprived areas elsewhere in the country , (Willmott 1992;Benzeval and Judge,1992). Changes in the health profile of the four local boroughs suggest an explanation for these health differentials may be one which is largely connected to a time lag effect between rapid and disproportionately worsening deprivation in London between the 1981 and 1991 Censuses and the knock on effect on health. The possibility that the selection of deprivation indicators or the spatial scale adopted can in some way account for regional disparities cannot be ruled out however. Analysis of deprivation statistics for the Lea Valley in this research showed differences in borough scores according to different composite indices. It was tentatively suggested that certain deprivation indicators may have greater meaning for some boroughs than others. It also demonstrated that the means of measurement considered- degree, extent and intensity- produced different results for individual boroughs. However, given the *overall* consistency evident for different deprivation indices and scales of analysis for the Lea Valley area, then these considerations are likely to be less important for the spatial patterning of health inequalities than the time lag effect already suggested. Local growth in long term unemployment may be particularly significant. Indications are that the upturn in the economy is making little difference to long term unemployment in the Lea Valley, therefore recent worsening of health indicators are unlikely to be halted as long as these trends continue.

The area contains a very high proportion of many of the social groups at greater risk of poverty and who are generally associated with poorer health chances: lower social class, ethnic minorities, social tenants and single parents The health evidence presented by Health Authorities, as expected, demonstrates that they are more vulnerable to a range of physical and psychological conditions. In the case of social class however, analyses based on the Registrar General's scale, far from distorting class related mortality differentials as suggested in sections of the literature, are likely to underestimate the extent of health inequalities locally, because of the disproportionate growth

in the 'unclassified or no job in the last 10 years ' Census category group in Lea Valley boroughs. Though the incidence of specific conditions is higher in certain ethnic groups, there is a danger that, by focusing on ethnicity, as Health Authority reports tend to do, underlying causes- particularly poverty, unemployment, and social class- may be given less prominence than they deserve. Similarly, a focus on health related behaviours can be in danger of neglecting underlying causes. Case study interviews undertaken as part of the qualitative side to this research illustrate how smoking for example is the outcome of a complexity of factors, including material and social deprivation and personal difficulties as well as attitudes. This research suggests that social class continues to be a valid focus of analysis in health inequalities because the concept encompasses a wide array of inequalities.

The structural analysis of Lea Valley boroughs suggested methodological reasons why 'concentrated poverty' may not be a useful term. When attempts are made to identify an area as one of concentrated poverty the spatial scale adopted will have implications for the amount of poverty found. It was suggested that the Lea Valley area is better described as one where poverty and deprivation are widespread, and an area where residents are multiply deprived. The qualitative interviews on the estates illustrated how aspects of multiple deprivation, including both material and social deprivation, combine to adversely affect health. However, secondary analysis of measures selected by Green to measure the extent to which sub group members (like the unemployed) are exposed only to one another, and which indicated high local levels of 'concentration' might well have implications for the composition of Lea Valley residents' social networks but would need to be investigated further.

It was noted that the poor are getting poorer in the Lea Valley, but the not so poor are getting poorer too. These observations on the changing spread of poverty and changing profile of those at risk are relevant to patterns of health inequalities, not only to possible changes in the distribution of health inequalities between social groups, but also because there are implications for Wilkinson's argument concerning the narrower the income inequalities in a society, the better the overall health standards of the general population. Perhaps it is the changing position of the poor themselves which does most to affect overall health standards. The position of the poor could be said to be a barometer for the health of a society in general. When the poor gain, as they did in the 1940s, the rest of society gains, but the poor gain most. When the poor lose, as they did in the 1980s and 1990s, we can all lose (except the rich), but the poor lose most.

One of the questions posed in this research concerned whether there are factors operating in a

locality other than the socio-economic characteristics of residents, and which could impact on health. Not all poor people are in poor health or die young, and, although social class largely determines area of residence, the literature indicates that some areas have worse or better health indicators than their socio-economic indicators would suggest. Analysis of statistics and other data relating to the Lea Valley highlighted some features of the local economy that are likely to be relevant for the health of resident populations. In particular, evidence on job loss, and rapid economic change, is likely to have an effect, so is the evidence on local people not benefitting from nearby economic regeneration. Perceptions of inequality- of the kind Wilkinson has suggested may be linked to health (Wilkinson,1990) - may well be important here. Structural analysis alone was not able to uncover those additional aspects of the locality which are the prime focus of this research, particular features associated with the local community, the perceptions of community held by residents, community solidarity and cohesion, and the composition and qualities of residents' social networks. Qualitative research on the two East London estates was necessary and was able to show the extent to which these features, as well as local policies and services, can make a difference to health and well being, at least to the largely subjective aspects investigated.

Social networks and 'looking after our own'

The qualitative research illustrated how and under what circumstances social networks affect health and quality of life , and showed that different network formations mediate poverty and health and well being in different ways. It explored relationships between the neighbourhood and patterns of residents' social networks, the relationship between residents' social networks and their attitudes and values, and the significance of these for their reported health status and commonsense ideas on health. It demonstrates that two factors in particular influence an individual's social networks: the place where they live and their social consciousness, particularly the extent to which they see others like themselves.

Place does make a difference. Features associated with the local neighbourhood, its social and employment history, its services, facilities, housing, casual meeting places, and opportunities for participation in local social and public life, as well as the area's reputation have influenced patterns of social networks in the two East London estates. Differences in the profile of each community contribute to dissimilarities in overall patterns of social networks found in the two case study areas. Influences on networks can occur in a direct sense, for example, where housing design encourages neighbourliness, as it does on many parts of Keir Hardie, or limits opportunities for interaction with neighbours, as it did on the low rise flats on Cathall. It can happen in an

indirect way also, in that a strong sense of community on Keir Hardie is indissoluble from characteristics of residents' social networks. Conversely, negative perceptions of the area held by residents on Cathall discourages many from interacting locally. In such cases, unless they have the resources and opportunities to develop their social contacts elsewhere, their networks will be impoverished, and, their health may suffer.

However, Keir Hardie and Cathall residents' values, including values of mutual aid and solidarity, perceptions of inequality and attitudes towards mixing with others, have also been shown here to be associated with the form and characteristics of residents' networks. There is a reciprocal relationship involved, values and attitudes are also influenced by the networks themselves, and, by extension, the characteristics of the place where they live. Values and attitudes however, are also influenced by a number of additional factors other than place of residence, and are connected with an individual's personal history. These include work and family history, their length of residence, participation in organisations and clubs in the past, as well as political and religious convictions.

Residents' networks on both estates were explored from a number of angles, and included the characteristics of the people in the network, the network structure -including density- and the functions and benefits that the networks provided. In order to simultaneously access as many of these characteristic as possible, as well as residents' attitudes to mixing with others, network models were constructed from interview data which related to the degree of similarity and dissimilarity of the membership groups which made up the network, and the range of positive and negative reference groups held.[1] Residents networks generally fell into five models: Restricted; Similar; Traditional; Pluralistic and Network of Solidarity. However, because aspects of social organisation on Cathall were more difficult to identify than on Keir Hardie, there were some residents on Cathall whose networks were entirely individualistic and did not fit any of these categories. They were Relocating and Innovative networks. In addition, there were residents on both estates whose lives were changing in some way, and whose networks were undergoing a period of transition. Nevertheless, the majority of residents interviewed had networks which corresponded to one of the five models.

What was striking about the network models was that health promoting functions of networks suggested by the literature, such as support, identity, access to wider resources, and health protecting or damaging attributes and attitudes, such as hope for the future, fatalism, pessimism, self

[1]Footnote: for an explanation of Bott's use of membership groups and reference groups, see ch.5.

esteem, perceptions of control, were all closely related to network type. Interestingly, behaviours associated with health, such as smoking, attitudes to food, and keeping fit, were also to some extent associated with network model. The importance to health of these observed relationships between characteristics of the network and health promoting or damaging attributes were confirmed by interviewees' reported experiences of health. For example, those with the more restricted membership groups had little support in terms of practical emotional or instrumental aid, were more likely to have low self esteem, feel powerless, fatalistic and had little hope for the future. They were also more likely to report that their health was poor than people whose networks corresponded to the other models. They felt anxious, depressed, suffered from headaches and stomach complaints, as well as a variety of other physical complaints.

These observations may of course, be simply connected to the network size: it is well established that the greater the number in a network, the better the chances of good health. Indeed size cannot be ignored, especially at the extremes, where networks are very restricted or very extensive. However, what *this* research also demonstrates is that social networks are not uni-linear phenomena. Some Keir Hardie residents for example have extensive social networks made up of members of a large localised extended family: a 'Similar' network. This can be very good at providing practical support such as help with children, or conferring identity, but the network can, in some cases, be controlling. People whose networks are made up of dissimilar membership groups will have access to different kinds of resources, including information and change of status, as in cases when someone becomes an officer of a voluntary organisation.

It follows then that the range of membership groups in an individual's network (on which the models are based) has implications for the mechanisms involved in the relationship between networks and health. A second alternative explanation is possible. The literature has suggested, as we saw in chapter 4, that network *density* has implications for the functions that networks provide, and these observations may simply be a reflection of structure. However, although the Restricted, Similarity, and Traditional models are all typified by a high degree of connectedness, they provide some different as well as similar functions. They help people to cope (or not) with poverty and life's problems in different ways, and affect their health in different ways. There is a third alternative explanation. I may simply be describing inter-generational differences in network models, and differences in membership groups connected with the life stage. Again, this cannot be ruled out entirely, people with very young children for example were more likely to lead socially restricted lives than those with older children or none. Age and lifestage cannot explain all patterns however; there are people of similar ages and household circumstances spread across all network

models. The explanation for the observed relationship between network model and health and quality of life adopted here is simply that a) different membership groups provide different benefits, and b) the wider the range of membership groups in a individual's network the larger the range of the potentially health promoting or protecting features associated with social networks.

Differences and similarities in network patterns in case study areas are related to characteristics of the estates. The Keir Hardie estate largely remains a traditional working class community, where residents have strong community loyalties, a strong sense of place and a shared sense of history, and strong perceptions of identity with the neighbourhood and the people living in it. Many parts of the estate are neighbourly, and population turnover fairly low. The traditional norm of mutual aid has to some extent survived changed conditions. The plentiful availability of local work in the past has made an important contribution to the area's cohesion and to the stock of social capital. It is however, a fairly insular community. Patterns of residents' social networks to some extent reflect local conditions and the history of the area, as well as the individual's personal circumstances. 'Traditional' and 'Similar' patterns of social networks reflect these traditional characteristics and are typical of the estate. The Traditional model in Keir Hardie is made up of memberhip groups of family, neighbours, ex workmates, old school friends and friends from social and sports clubs. Like the Similar group, the structure is tight knit, and residents are closely attached to the neighbourhood. Mutual aid and 'looking after your own' are dominant values.

Pensioners in this group are active in social clubs, their present activity is rooted in their experience of work in the past. This has given them something of a collectivist outlook on life. Traditional network models are found on both estates, but in Cathall, which has not been a work based community, where continuity of residence applies to some extent to the older generation but not the younger, and where community sentiments were much less strong, they exist in a paler form. The effects of social and economic change mean that on both estates residents in the traditional category are a diminishing group, more typical of the older generation than those of working age. On Keir Hardie the 'Similar' group appear to be taking their place, on Cathall, the picture is more fragmented. Compared to the relatively anomic Cathall, there were a relatively large proportion of residents amongst those interviewed on Keir Hardie whose networks fell into the 'Similar' model of strong, tight knit local ties of similar people, particularly family ties, and a strong sense of local attachment. It is perhaps associated with a traditional community which is less strong than it once was, a traditional community which has lost some of its essential features- particularly local work, and good provision of social, youth clubs and other facilities, but which has never the less managed to remain reasonably resilient. These observations are to some extent congruent with aspects of

Giddens' structuration theory. He argues that structures survive over time because of the duality of the relationship between structure and action. Structures make social action possible, at the same time that social action creates those structures, (Giddens, 1984) .

Cathall, in contrast to Keir Hardie, is not an 'attachment community'.[2] There is little sense of pride in the area, little sense of history. Alienating housing design, crime and fear of crime, anti- social behaviour, population turnover, so called 'dumping ground' housing allocation policies of the 1980s, have made it difficult for people to develop local social networks and undermined any sense of community. Rather than neighbourliness there is distrust between residents, family dispersal and strain rather than a local supportive extended family, anomie rather than strong local culture and values, alienation rather than attachment to the community. 'Keeping self to self ' attitudes are prevalent. All of these features can be health damaging. However, plentiful opportunities for involvement in projects, self help groups, tenants groups as well as courses, toy libraries and so on mean that there is a thriving positive community which co-exists with the demoralised community and has developed in parallel to it.

For many residents interviewed however, the locality is a much less dominant aspect of people's networks on Cathall than on Keir Hardie. Residents involved in tenants groups and voluntary organisations are an exception: as on Keir Hardie their networks can be loosely grouped as 'Networks of Solidarity'. For many of the remainder of those interviewed, social networks are either very restricted, or dispersed in some way. Aspects of social organisation on Cathall is more difficult to identify than on Keir Hardie, patterns of residents' social networks are wide ranging, individualistic, and personal. On Keir Hardie models of social networks could be seen to reflect to an extent, features of social class in a traditional working class area, where social organisation, despite evident changes, in some respects remained fairly static. On Cathall, the difficulty in grouping people into network models may be a reflection of a more fractured working class, itself a consequence, in part, of rapid social and economic change visited on the area.

A higher proportion of those interviewed on Cathall had networks which currently or in the past corresponded to the 'Restricted' model of restricted membership groups and restricted numbers within those groups, and descriptions of life on the estate reported by both residents and professionals suggest that these are typical. Compared to Keir Hardie residents with Restricted networks, this phase of their lives was of much longer duration, and the causes tended to be

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[2]Willmott's use of the term attachment community is described in chapter 2

different. The personal circumstances of some Keir Hardie residents with Restricted networks were contributory factors, and included a violent partner. On Cathall, it was as, or more likely to be the place itself. Alienating conditions on Cathall were clearly acting to restrict residents' social networks. A fear of crime, and other indicators of a lack of trust, in some cases made residents afraid to go out. For those who arrived with already restricted networks, living on Cathall acted to exacerbate their isolation and consequently poor health was more likely. The contrast between the two estates confirms the relationship between perceptions of the area held by residents, and the degree to which they mix with fellow residents. Local social networks can be seen to mediate perceptions of community and health.

On Keir Hardie the Similar network model predominates, on Cathall, it does not appear to exist in its pure form. Because Cathall was not a desirable place to stay, because the proximate extended family was not a strong feature of the estate, there were no residents interviewed whose networks coresponded to the Similar model, at least in the localised sense. The apparent paucity of such residents suggests, not that Cathall is a working class community which is less strong than it was, but, that it is a working class community which, in most generally accepted usages of the term, has at worst ceased to exist or at best, is struggling to remain viable. Resourceful individuals, whose networks might well have been described as 'Similar' or 'Traditional' had they been living in another environment, did their best to disassociate themselves from the estate and establish friendship networks for themselves and their children elsewhere. Their networks were 'Relocating'. Where these were successfully established, their health did not suffer.

Residents with Networks of Solidarity were found on both estates. Indeed, residents' social networks on Cathall appeared to some extent polarised between Networks of Solidarity at one extreme, and Restricted networks at the other, along with a disparate, innovative range of networks in between. Networks of Solidarity differ slightly between the estates as Cathall residents cannot always rely on as much support from local family and friends as those on Keir Hardie, but the other elements in this model are similar on both estates. Residents have a wide range of membership groups, consisting of similar and dissimilar people; they have many positive reference groups and a network structure which is both dense and loose. They are active residents, involved in a range of organisations and groups. On both estates these residents are highly committed to their community, on Keir Hardie this does not distinguish them from residents in other groups (except the Restricted) , on Cathall it clearly does.

There are similarities with the Roseto model, where a high rate of participation was linked to low

rates of heart disease, (Wolf, and Bruhn,1993). But Roseto was a homogenous society, they were all Italian Catholics. The networks of solidarity in East London encompass dissimilar as well as similar people, and open outwards. Attitudes are less likely to share the parochial element common to the other networks.

Putnam uses the term 'social capital' to refer to our relations with one another. It encompasses certain features of social life, in particular networks, norms, and trust. Social capital can involve both social and political activities but Putnam is particularly interested in civic engagement, or participation. National data he examined suggest that America's stock of social capital - as evidenced by participation in voluntary associations - has declined in recent decades. The decline is recognised as affecting all sections of society, and various types of communty-cities, suburbs, small towns and the countryside. The culprit, for Putnam, is television. Looking at national American Survey data from the 1940s onwards, he discovered that "Controlling for income, age, race, place of residence, work status, and gender, TV viewing is strongly and negatively related to social trust and group membership ", (Putnam,1995, p .678). Though TV is certainly likely to have an effect on participation in Britain at the national level, as well as on other forms of social interaction, it cannot account for differences between East London estates in social connectedness and participation, nor in differences in trust between residents.

Sustained community development work, dynamic tenants organisations, the HAT activities, mean that there are more opportunities for involvement on Cathall estate than on Keir Hardie, and one would expect therefore, more participation in associations and groups than on Keir Hardie. Greater levels of participation on Cathall cannot be assumed from this research, more rigorous investigation would be needed. There are blocks to involvement- and therefore health promoting networks- on both estates. Community has to be made on Cathall, a spur to some to join tenants committees, self help groups, and become involved in child care and community development projects. But there are many others for whom the general alienating conditions on the estate and feelings of distrust, make them perhaps more disinclined to join things than people might on a more socially cohesive estate, like Keir Hardie. Putnam has suggested that social trust and civic engagement are highly correlated. Trust itself, he suggests, derive from interaction with others, the more we connect with other people,the more we trust them, (Putnam,1995). Lack of trust and minimal local social interaction are highly correlated on Cathall.

On Keir Hardie, however, resistance to becoming involved comes, not from lack of trust, but from another source: the predominant traditional value of 'looking after your own' appears to make

mixing with a different set of people unnecessary. There are additional reasons, unconnected to attitudes to others, why people don't join activities. People on both estates are poor and deprived. They may *feel* fatalistic and powerless, but they are not accustomed to getting what they want, are used to the *reality* of being powerless, as opposed to the perceptions of powerlessness. As a resident on Cathall put it "Why join anything, or go on courses. People round here think that no-one on this estate ever gets anywhere, so why bother". In any case, people are constrained by their situation, their problems and struggles to make ends meet may be so overwhelming that there is little energy left over for anything more than essential day to day activities. An active resident on Keir Hardie put it succinctly: "You can't take away from people and then expect them to help themselves. If you are poor there is only so much you can do".

Nevertheless, how people define 'their own' is crucial, crucial for an individual's social networks, for their attitudes to the community, for social cohesion, and for their health. For the Similar group on Keir Hardie it is largely local family and sometimes neighbours; for the traditional group (on both estates) family, neighbours and ex neighbours, old workmates and friends from clubs. For both of these groups on Keir Hardie, it is also, importantly, 'Canning Towners', and/or people in the block or street. Solidarity with one's fellows here is only partial, a 'conditional solidarity' perhaps, limited to people like oneself, and does not include outsiders or people who are different. In contrast, those with Networks of Solidarity on both estates see interests in common with a very wide range of people and groups, they have a wide range of positive reference groups. Racist attitudes for example, are not found here.

It is not clear whether the attitudes to others or the networks come first, whether the values are influenced by the networks or the networks develop from the values, but they are likely to develop in tandem. There is likely to be a reciprocal, dialectical process involved here - greater involvement leads to broadened networks and to attitudes of solidarity which in turn leads to a further expansion of social networks. The propensity to see others like oneself preceded involvement in some cases, some active residents reported that they had always had slightly different attitudes from the local norm. A woman on Keir Hardie for example believed that she was more tolerant and open to ideas than other Canning Towners because she had mixed race in her family, and a brother who was gay. However, comments made by some residents involved in tenants groups on Cathall indicate that they have learnt to be tolerant. Involvement has broadened their networks and introduced them to different ideas and cultures. Nevertheless, what is clear is that networks , attitudes, and the activities residents are involved in have health promoting qualities. Broadened networks provide access to a wide range of support and resources. People feel

in control of their lives, their self esteem is high, they have a sense of identity, and they have hope for the future, for themselves, their families and their community. Of course, the relationship between activities and health could be much more direct. People who feel happy and healthy in the first place could be those who are more likely to become involved. An element of self selection cannot be totally ruled out. However, there were residents on both estates who described how becoming involved had changed their lives. Their networks had grown, they were enjoying life, and for many, their health and sense of well being improved also.

For residents on Cathall and Keir Hardie, involvement in organisations, activities and self help groups like credit unions and support groups, provided for them many of the benefits to health which are associated with employment, and which were described earlier in chapter 3. Participation, like work, conferred self esteem, feelings of power and control, a sense of participating in a wider purpose. Participation was a source of social status and identity and gave a time structure to the day. Residents reported that it also took their minds away from their problems. It has been suggested elsewhere that the health giving benefits of work only apply where work is satisfying. Graetz showed that unsatisfying work could be worse for health than no work at all, (Graetz, 1993). The literature was not clear however, about what it was about work which was satisfying or not. For Keir Hardie residents who had worked in the Silvertown factories it was solidarity with others, companionship, which were the dominant features of accounts of their working lives. It was these things, the social aspects of work, which made work *satisfying*. Their accounts illustrate what were for them, some of the health promoting properties of work. The contacts they made, the social skills learnt, the self esteem they derived , the support they gave and received continued throughout life, and sustained them.

Participation does seem to compensate here for lack of work. In many cases, such involvement was likely to be more satisfying than the kind of work available to unskilled people should it have been possible to get it. The only, but important exception to the compensatory benefits of participation is money. Active residents on Keir Hardie and Cathall are still materially deprived, but do not suffer from the additional damaging health effects associated with social deprivation. In this way it can be seen that participation, thriving social networks, are even more important for the health of the poor than for the non poor and employed. This analysis to some extent confirms work by Whelan who, although not considering the effects of participation, found that 'social support' has its strongest effect on psychological health at the highest levels of deprivation, (Whelan, 1993).

Active individuals were motivated to become involved in organisations from a desire to improve

conditions on their estates. Some were also motivated by religious or political conviction, and by their perceptions of inequality. These residents were driven in some cases by a hatred of the poverty they saw around them and of the inegalitarian society we live in. Residents with Networks of Solidarity are as committed to their community as the residents in the Similar and Traditional groups on Keir Hardie, but here, for the Solidarity group, the community is wider, much less exclusive, more inclusive. It has been suggested that *perceptions* of inequality may be damaging to health (Wilkinson, 1990) as well as the reality of inequality. And yet, strong perceptions of inequality could co-exist with the solidarity and mutual aid evident in the kind of cohesive 'traditional community' we tend to associate with properties which are of benefit to health. Strong union membership and activity for example characterised some of the neighbourhoods described in the classical community studies literature. However, my research suggests two things: 1) that the nature of the *response* to perceptions of poverty, deprivation and inequality as well as the reality of experiencing it has relevance for health outcomes in todays deprived communities; and: 2) how *the structure of inequality is perceived*, is important too.

(I) Responses to poverty

An internalised response, feelings of passivity, fatalism, hopelessness, stigma derived from being on benefits or living in an area with a bad reputation, are evident in those whose networks correspond to the more restricted models. Their health was poor also. Fatalism may be in many cases a realistic response to the reality of powerlessness but the consequences are the same. An understandable giving up on coping in some cases and the health damaging consequences that Wheaton has demonstrated.[3] Case examples have illustrated how attributes which the literature has shown to be health damaging, and which are linked to lower social class and poverty- particularly lack of control and fatalism- interact. They interact in a social network which is either very restricted or consisting of people largely like oneself, and a situation where people see little need , or have little opportunity, to broaden their positive reference groups and to identify and mix with others. Fatalism, relating to one's own life and the way society works in general, and political cynicism are associated with a disinclination to join organisations and groups to try to change things. Parochial attitudes however, are very much part of the picture too.

In contrast, an externalised response , hoping for something better, acting collaboratively and collectively to change things, for others as well as oneself, produces the reverse, feelings of control, enhanced self esteem and better health. There are probably a multitude of possible responses,

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[3] See chapter 4.

including a range of individualistic, creative and eccentric reactions necessary to any vibrant and tolerant society, some of which are evident on Keir Hardie and Cathall. However, the first response is associated with residents who have restricted membership groups, the second, with those who have wide membership groups and open positive reference groups.

What is it about membership groups which is protective or damaging to health? As we have seen, certain attitudes and values which can have relevance for health are associated with network type. There is an added dimension however. A major aspect of how people respond to poverty and deprivation which came across in residents' accounts of their lives concerns how they cope with poverty and life's difficulties.. Their social networks help them to cope (or not) in different ways. Different membership groups allow the adoption of different coping mechanisms. The wider the range of membership groups in a individual's network, the greater the potential benefits for health. Membership groups made of up similar persons to oneself- such as family- help people to cope in certain ways, like providing practical support. Membership groups made up of dissimilar people help people to cope by providing access to different kind of resources, like information and status. The extent to which they are able to cope has implications for their health and well being.

Some cope actively, some passively, and some interactively. People with more restricted models- the Restricted or narrower end of the Similar group- don't cope. They lack resources and help. For some, life has been hard, and characterised by poverty, having children young, and difficult relationships with partners. In response to debt, stress, bereavement and relationship problems, many on the estates turn to smoking as a coping mechanism, or take anti-depressants. Many of those (non Muslim) residents interviewed with both Restricted and Similar membership groups considered smoking as an essential coping mechanism and implied that it was beneficial to their mental health. For example "I'd be a lot worse without it". A combination of fatalistic attitudes plus lack of information may be playing a role here. It has been suggested that giving up smoking is particularly difficult when your self esteem is low, you feel powerless and pessimistic, (Marsh and MacKay, 1994) all attributes which, as we have seen, are more commonly found amongst estate residents whose networks are 'Restricted' and, in many cases, 'Similar'. These observations suggest a relationship between attitudes and coping strategies as well as attitudes and health related behaviours.

Residents' accounts of their life experiences and of managing their lives are reflected in their attitudes to health. No one in the Restricted or Similar groups made direct links between smoking and ill health for example. People's accounts of their health experiences and commonsense

attitudes to health are constantly interwoven with stories of relationships. The more restricted the network, the more dependence on individual members, and the quality of relationships becomes crucial. A non supportive partner for a woman with young children with restricted networks for example, has greater implications for health effects than for a woman with many contacts. Some of the women with restricted networks linked a violent partner with their own low self esteem, feelings of lack of control and poor physical and mental health. They had few sources of support available to them.

The extent to which people in the Similar model cope depends to some extent on the quality of relationships in the network. Family members provide support, such as help with child care or financial support, but it frequently isn't enough to meet needs, and there may be family conflict. Friends can provide emotional support, but because membership groups consist of people like oneself, they are not able to help with accessing other resources, such as information, including health information. The tight knit structure of the networks, the similarity of the people in their networks, mean that network members can provide little relief when negative life events- particularly bereavement- strike, and may even act to compound their unhappiness. Other family members are too involved themselves to be supportive.

Again, their life experiences were reflected in attitudes to health. Those who had experienced bereavement for example saw clear links between these events and their own deteriorating physical and mental health. Several of the women interviewed in the Similar group felt that having children young had curtailed their social networks, and had contributed towards their financial poverty. Their experiences are perceived as affecting their ability to cope, and their health. One simply expressed it as "never having a chance to enjoy life". Residents in both the Restricted and Similar groups identified various aspects of material deprivation which they connected to ill health. Worrying about making ends meet was seen by many as detrimental for health, mental health especially, but physical health also, as well as inadequate housing or overcrowding, and the isolation which can accompany living in a tower block. Several made connections between *stress* and ill health, and mentioned stress in relation to money, relationships with men, and problems with children. These findings confirm those of a national study which indicates that over two fifths of men and more than half of women felt that stress harmed their health (HEA/ONS,1997) but research on Keir Hardie and Cathall also suggests that these proportions would be likely to be higher if research was restricted to deprived areas.

Those in the Traditional model cope, like those in the Similar, with a certain amount of mutual aid.

This is particularly clear in old age, when friends shop and cook for each other and family members help during illness. Interestingly, the stories of mutual aid in the South Canning Town of the past often involved exchange of food, and these experiences appear to influence attitudes to both health and sociability in the present. Good food is perceived as important for good health by many of the Traditional residents, and food also features in social activities. In contrast, health promoting behaviours including eating healthily do not crop up in interviews with residents with restricted networks, where food was mentioned, residents had a somewhat ambivalent attitude to it.

Families, though a prime source of support for the elderly, can sometimes be a mixed blessing, and people in the traditional group were better able to cope successfully because they had other membership groups- including supportive friends, to balance their lives. Experience of working locally in the past, membership of social clubs, had given individuals something of a collectivist outlook on life. Their experiences and build up of resources- social capital- helps them to cope with life and health problems. Participation in social clubs brings may benefits. It keeps them active, they are pleased to be doing something for others, and they can indulge shared memories.

The Traditional group laid great stress on the value of coping in adversity, of getting on with it , taking what life throws at you, not making a fuss. A stress on coping is reflected in attitudes to ill health and negative life events. Having friends to get you through bereavement was highlighted by some but so was the necessity of being strong enough to cope with it. Being strong willed is seen as a virtue, as is managing your income, not getting into debt, being in control, all of which are also perceived as important for health. Although these traditional East Londoners believe that keeping active is important for health and well being, it is still something of a passive, fatalistic kind of coping. They don't seek help, or try to remedy situations from external sources. Coping can include not wanting to bother the doctor, and not admitting to any concern about health problems. Despite the desire to remain in control over health issues, not give in to it, their attitudes to health include (as they do in the Similar networks) a strong streak of fatalism, especially where smoking is concerned.

The Pluralistic group, whose networks are made up of a wide range of dissimilar people, cope *actively*, they are well informed, they are able to access a range of resources to help them cope with poverty. They gain real feelings of achievement from involvement in activities, and have a sense of personal control. There is no defeatism in their attitude towards life. Just as they believe that they have some control over their environment, and can take an active part in achieving change, so they recognise that they have a role to play in protecting their health. They take notice of health

promotion advice and act on it, they use the health services and make demands on them. Indications that people in the Restricted, Similarity and Traditional groups do not take note of health promotion advice, suggests that take up is connected to the composition of residents social networks. A wide range of membership groups providing a wide range of access to information is clearly important.

Residents whose networks correspond to the Network of Solidarity cope *interactively.* Like the Pluralistic group, they have the advantages which being active in organisations can bring, but like those with Traditional and Similar networks, can access the support of close personal ties. Their wide range of reference groups means that they are willing to interact with a wide range of people who are both dissimilar and similar to themselves. They are able to withstand a certain amount of negative life events, not by 'getting on with it' but because they have built up social capital.

The networks which are potentially most health protecting or promoting will balance egoism with altruism. Although potentially the balance is more likely to be achieved by people whose networks correspond to the solidarity model, for some individuals, altruism is more evident than egoism. Reciprocity appears to be the key for health and well being. Some residents give a lot, but for the sake of their health, may be giving too much, and not receiving enough back. When residents felt overloaded, they spoke of feeling out of control. Participation in self help organisations however, appeared to be particularly beneficial to the quality of life for those interviewed. For Durkheim, psychological health and a sense of well being is generated by social orders in which the 'collective conscience' is made up of a balance between individualism (egoism and anomie) and collectivism (altruism and fatalism), (Durkheim,1897). Contemporary 'Communitarian' ideas similarly identify a lack of balance in modern society between individualism and collectivism, a balance which has swung too far in the direction of individualism., (Etzioni, 1993). A problem with Durkheim is that it is not always clear what level of 'social order' is being referred to: society as a whole, the community, or the group. Research on Cathall and Keir Hardie has focused on the micro social system, the social network. At this level better health for the individual is evident where the network has the potential to balance egoism with altruism. The East London research has also looked at the community level. Here, it was not the balance of Durkheim's four moral forces which was found to be significant, but patterns of social networks and the social cohesion of the community a whole. Durkheim's 'intervening institutions' play a role, in providing opportunities for participation, but so too do a range of additional features making for cohesion and solidarity.

For all in the Solidarity group, their quality of life was connected with the satisfaction of present involvement in local life. Keeping fit, getting out and about, were seen, as they were for the

Pluralistic group, as important for health, as was meeting people . As might be expected from a well informed group, residents identified a wider range of social, economic, environmental and political circumstances which could affect health, than those with fewer membership groups. As with people in other models, relationships were seen as important for health and well being, but the women in this group tended to be much less dependent on partners, and some valued their independence from men. Most recognised the importance to health of a supportive family and friends.

As well as similarities on the estates between how people in certain network models- Restricted, Traditional, and Network of Solidarity- were able to cope, there were also differences overall between the two estates. As on Keir Hardie, people on Cathall talked about coping with poverty, but on Cathall they were more likely (amongst those interviewed) to talk about coping with a deprived, stigmatised and socially disintegrating estate. To cope, people need to be *innovative* on Cathall, they cannot rely so much on traditional structures of family and neighbours- especially the latter- as they do on Keir Hardie. The networks simply don't work as well as on Keir Hardie, where community life is much stronger.

Innovatory coping mechanisms evident on Cathall included disassociating oneself from the estate, and becoming involved with people outside the estate, by, for example, avoiding walking through it, taking children to schools outside the area, paying for children's leisure activities outside the estate and discouraging them from playing on the estate; and establishing friendship networks in a totally different location. One individual turned inwards, "retreated" to use Merton's term, from the neighbourhood, though not from society at large, by keeping up appearances in the home. This can lead to debt, anxiety and ill health. Another individual coped by subverting the system, and adopting aggressive and sometimes violent tactics.

(ii) Perceptions of the structure of inequality

How residents perceive the way that inequality is structured has implications for their networks and their health. Those with a narrow range of positive reference groups tend to see themselves in competition with people who they perceive as different from themselves, but who on many counts are little different. They can be people getting higher benefits than themselves, the person in front of the queue at the post office getting a better pension, or the person in a bigger council house. These are poor people too, but are perceived to be different and to be less deserving. Sometimes race is an issue. These residents similarly have a wide range of negative reference groups. They see few other groups as like themselves. They tend to be those with the Restricted, the Similar, and in some cases, the Traditional membership groups. Attitudes of looking after your own grow from

a situation of scarcity. A widening of reference groups involves seeing a wider array of groups as like oneself. A wider solidarity, does to some extent appear incompatible with a situation of scarce resources.

Conversely, those with a broader range of positive reference groups do not see lines of division quite so close to home. They tend to see inequalities between rich and poor as the important ones, and between social classes. They are willing to mix with a broad range of people, both on the estate and from elsewhere, they are active in organisations, and their networks broaden into a wide range of membership groups. In this way, forms of social consciousness including solidarity - recognising shared interests with dissimilar individuals and groups- can be seen to be beneficial to health. I began by confirming the relationship between class, poverty and health for the region. The qualitative studies on Keir Hardie and Cathall have helped to demonstrate how wider aspects of class- particularly class consciousness- have a role to play also. Social consciousness impacts on health through the mediating role of social networks.

The models illustrate how the distribution of resources and support, and health, varies with characteristics of the network. It could be argued that the network models described here, based on the range of membership groups in the network, are simply a reflection of the class structure, that they are describing some of the ways in which social class impacts on health. Middle class people, it is generally accepted, have wider networks and greater access to resources, as well as, generally, better health. As Pearlin point out, just as the distribution of wealth, power and status are unevenly distributed in societies, the extensiveness and resourcefulness of their networks is unequally distributed too, (Pearlin, 1985). However, almost all of those interviewed on Keir Hardie and Cathall are from semi skilled and unskilled backgrounds, and are poor. The network models based on membership groups described here are not simply a reflection of a system of inegalitarian distribution of resources - even within different segments of the poor and working class. However, the idea that what is being described refers to nuances in a hierarchal system of social classes cannot be totally ruled out. Although many of those who were active in organisations and activities were hard up, they tended not to be people in the worst housing. The active groups also included people, who, though they may have lacked a formal further education, were nevertheless highly capable. A recent Basic Skills Agency report, based on National Child Development Survey Data links low literacy with increased risk of depression, as well as with low wages or unemployment, and a lower likelihood of belonging to community organisations, (Byner, and Parsons, 1997). In East London such slight differences evident in material and educational advantages however cannot totally explain the overall patterns in social networks. Nor can they explain differences between

estates.

Features associated with each estate have a role to play in shaping attitudes and developing networks. Attachment to the place and to the people who live there differs markedly between the two estates. The social glue of the community in the past on Keir Hardie was plentiful local work. The availability of work locally was a strong feature of accounts of classical British community studies. "Ashton" for example, Dennis, Henriques and Slaughter's' Yorkshire mining town (Dennis et al, 1957) was dominated by the pit; miners formed strong bonds with their fellow workers, the solidarity of the pit face carried over into trade union organisations and from there to leisure activities. Bethnal Green in the 1950s had plentiful local work, as well as close knit kinship networks and strong community loyalties, (Young and Willmott, 1957). The Keir Hardie estate, with its stable population, local extended families and strong sense of belonging, is in many ways, similar to the Bethnal Green of the 1950s. The key difference now however, is employment. The majority of those interviewed in South Canning Town were not currently employed. Plentiful local work in the past however had helped to foster strong community sentiments.

Both estates are changing. In the case of Keir Hardie the experience of change has been long term, and dates to the 1970s. Many of the features which have helped to build up the community and social capital on Keir Hardie have disappeared or are declining rapidly and it is clear that the community will not be sustainable indefinitely without help. The estate has been remarkably resilient in the face of so much neglect. But the question remains, how long will it remain so without considerably more extra resources and help, and jobs. Plentiful local work, social clubs, youth clubs, local shops- are all features which are part of the past experience of the over 40s. Younger people are missing out on many of these activities and features of an area which develop social networks. In addition, some, including young single parents, are in tower blocks unsuitable for young children, and reportedly, the blocks are not neighbourly. Some young people are said to be involved in crime and drugs as well as anti social activities. The health of the young as a group on the estates has not been specifically investigated here, but, if, as Blaxter has suggested, social networks are particularly important for the health of the young, then these changes and conditions, if replicated at the regional level, could help to explain disparities between the health experience of younger and older people reflected in health statistics and mentioned in chapter 6. Changes in poor areas, including tendencies to social exclusion, may also have some relevance for trends in national health statistics. Mortality inequalities between deprived and better off areas have been growing in recent years, and particularly affect men aged 15-44,(Dorling,1997).

If work was once the social glue on Keir Hardie, then the 'social dissolver' on Cathall was alienating housing design and insensitive allocation policies. Cathall is also changing, in its case, for the better. The HAT housing rebuilding programme and intensified community development work, community policing, designing out crime, are doing much to raise the collective esteem of the area and people in the new housing are already reporting a change in patterns of neighbourliness and relationships of trust between residents. Keir Hardie and Cathall each have elements which can contribute towards the formation of a health promoting community. Keir Hardie has, or had, the traditional aspects of a working class community: a history of local employment, stability of population, as well as neighbourness and strong attachment to the neighbourhood. Cathall has plentiful opportunities for involvement. Wilson has argued that a weak institutional base - lack of facilities and resources- is something which distinguishes high jobless inner city areas in America from stable ones. He also suggests that an institutional resource base is strong where the links between the community organisations, such as churches, schools, political organisation, business and civic clubs are strong. One of the notable features of the resource base, in terms of facilities, initiatives and organisations, on Cathall estate was the strong links between the different agencies. An emerging 'community of professionals' was evident. If these trends continue, then the residents on Cathall are likely to benefit. Wilson also suggested that, where these strong links exist, it is easier for parents to control the behaviour of children, (Wilson, 1996). If the anti social behaviour of children on Cathall is eventually turned round, then residents perceptions of the neighbourhood are likely to change for the better, their networks are more likely to expand, and they will derive some of the potential benefits to health from both fewer perceived hazards and boosted social networks.

Concentrated poverty, social exclusion and social cohesion

One of the questions addressed earlier was whether 'concentrated poverty' can have an added-on effect on health. Wilson, writing on the ghetto poor in American neighbourhoods, describes the development of 'concentration' in particular areas as a consequence of high joblessness, out-migration of those in work, and movement of poor people into a neighbourhood, (Wilson, 1996). Problems associated with concentration, including crime, family dissolution, welfare, low levels of social organisation , and so on, are, he believes, primarily a consequence of the disappearance of work. Better off (ie with a higher proportion of employed) neighbourhoods have higher levels of social control, cohesion and social organisation - including social networks- organisational services and social support (Wilson 1996). Others have added poor health to the concentration effect, (Massey et al,1994).

On Keir Hardie and Cathall, a preponderance of the poor and unemployed, does, to some extent, restrict opportunities for widening membership groups to include employed people, and therefore restricts the potential for health benefits of wider networks. However, the relationship between unemployment and social disintegration in East London is complex. Different local histories, and different opportunities for making contact with others, as indicated earlier, have produced different network patterns on Cathall and Keir Hardie. The differences, though not the causal relationships, have little to do with the proportion of the poor and unemployed, the estates are similar in that respect, as they are for at least one vulnerable group- single parents. What has been shown here to be important for networks as well as health and well being, is not simply whether or not one is living next door to someone who is unemployed - most residents on both estates do so- but whether features relating to the social organisation of the area are helpful or not. There is not a miasma effect, but characteristics of the area which are over and above the socio- economic characteristics of residents do have a role to play. An area's stock of social capital affects health irrespective of the resources and attributes of individual residents.

Of course, once an area becomes one of high unemployment, then decline is more likely than in better off areas. People on both estates- as people in deprived areas anywhere- may have been less able to stop services and facilities (including opportunities to live a healthy life) declining locally than in better off areas where residents have more resources at their disposal. However, in certain circumstances people do get together to fight to make improvements. Residents on Cathall were successful in lobbying the DOE for the estate to become a HAT, at least in part because the structures and support for involvement were already there and because they had help from local MPs and the Local Authority. Quite different circumstances encouraged involvement in a campaign on Keir Hardie. The threatened closure of the 'Cathedral of the East End' touched a collective nerve. It was one of the few buildings left standing after the blitz during the second world war. Each estate had different forms of social capital on which to draw. All things taken together however, day to day neighbourliness and thriving social networks on Keir Hardie estate, means that this estate has more of it.

Yet Wilson's focus on the effects that the disappearance of work has on the individual, the family and neighbourhood life *are* pertinent here. The plentiful availability of local work in the past on Keir Hardie did much to contribute to the area's stability, and to build up its store of social capital. Positive aspects of the social organisation of the area has been sustained, to some extent, into the present, but there are indications that it is changing.

Are people on the two estates socially excluded? Are they cut off from mainstream political, economic and social life and from mainstream values? Features which act to 'include' people and exclude them differ between estates as we have seen. High rates of unemployment mean that many experience economic exclusion on both estates. Social and political participation (in terms of attitudes, voting and activities) varies however across estates with network type, and between estates. Only those in the most restricted groups are excluded socially from their local community. There are more of these on Cathall however, due to the alienating conditions on the estate. As far as mainstream values are concerned, this research has shown that people in the East London neighbourhoods can have a variety of values and attitudes, and that these vary with characteristics of their networks. However, residents across all network types on both estates were united in their anger at a lack of jobs and lack of facilities for the young, as well as a decline of services.

There is some reported evidence on the estates of a breakdown of cultural values amongst some of the younger residents. Anti- social behaviour was mentioned by residents, as well as crime, drugs, and sexist and selfish attitudes of young men, particularly on Cathall. Although relatively high crime levels on Cathall are not in dispute, the evidence on young people as a whole on both estates is patchy however and would need further investigation. However, there was a clear divide in residents' accounts on Keir Hardie between the opportunities available to the over forties to lead a healthy life when young,and todays younger people. The over forties had jobs, clubs, leisure facilities, and more meeting places in their youth. If values are changing, then structural changes are likely to be implicated. Wilson's ideas on changes in American ghettos are relevant here. Culturally destructive behaviours, he believes, emerge from blocked opportunities to realise mainstream aims, and the struggle to live up to mainstream norms. He suggests that a form of social isolation which deprives people from mainstream social networks which facilitate social and economic achievement contributes to the formation of ghetto related cultural traits. The point is similar to Merton's earlier theory on deviant responses to blocks to the achievement of goals prescribed by society (Merton, 1957).

This research has shown that social networks can mediate poverty , deprivation and ill health in different ways. Of course, on Keir Hardie and Cathall there were people whose resources were so low and needs so great that whatever help and other benefits their networks were able to give it was always likely to be inadequate. The large family of young children in a no earner household living in a top storey flat on Keir Hardie is an example. Another is the low earner family with six children and disability in the family in a Cathall flat. Although facilities, services, opportunities to lead

healthy lives have been shown to vary between the two communities, national, as well as local policies of re-distribution are important for the quality of peoples lives. The HAT is spending huge sums of money (on average £122,000 per family) on rehousing Cathall residents but many residents on nearby estates, however, continue to put up with poor conditions. Moreover, residents on Cathall are still poor, many will find it difficult to pay the new, higher rents. Many residents are likely to remain unemployed. Economic re-generation may bring new jobs to both areas, but past experience of large scale re-generation has indicated a tendency for new jobs - at least the better ones- not to go to local residents. Small scale training, business support and job creation schemes in operation or in the pipeline are encouraging but likely to be a drop in the ocean given the very high proportion of unemployed on both estates.

The research in East London can be used to conceptualise social cohesion at the neighbourhood level. [4] It builds on Willmott's concept of ' attachment community' to add inclusion, and tolerance. An adequate distribution of resources, facilities and work are a precondition. Willmott's attachment community combines interaction with others with a sense of community and identity with a place or group and solidarity with fellows (Willmott, 1989). Conditions of the East London estates which encourage the development of social networks and a strong sense of community include continuity of residence, sociable housing design, sensitive housing allocation policies, opportunities for casual interaction and local services, clubs and other facilities, and importantly, plentiful local work. All indicators of a 'sustainable community', But that is not enough. Many of these characteristics foster solidarity, but it is a partial 'conditional solidarity' only, people who are not seen as similar to oneself can be excluded. Opportunities for involvement in initiatives and organisations can provide conditions for the inclusion of unlike groups, and for fostering tolerant attitudes These will be more likely to be effective where social capital has been built up already, where neighbourliness and trust, and friendship characterises relationships between residents. People on both estates were more likely to take up opportunities if a friend or neighbour was involved. The point has also recently been made elsewhere in a study linking social capital with mortality. "Belief in the goodwill and benign intent of others facilitates collective action and mutual co-operating and therefore adds to the stock of a community's social capital", (Kawachi et al,1997,p1492).

However, a situation of scarce resources can act, not only as a block to involvement, but work against tolerance and inclusion. Adequate resources- including benefits, pensions and housing- are

[4]A recent conceptualisation of social cohesion defines socially cohesive areas as those with high levels of interaction and a strong sense of community, (Hirschfield and Bowers(1997)pp.1275-6)

a pre-condition for a larger number of residents to widen their range of positive reference groups and for wider solidarity. Social cohesion, as defined here- attachment, inclusion and tolerance- is beneficial to health, through residents' social networks consisting of a wide range of membership groups- and the benefits to health which that can bring, and positive perceptions of the place where they live and the people living in it. For Titmuss, social cohesion, at the national level, referred to re-distribution through fiscal, social and economic policies, (Titmuss,1987).

In *Community, equality and health* (Cattell, 1995) I tried to identify features which, in general terms, would make for positive, healthy communities. The analysis referred to communities in a general, abstract sense, but is relevant for the East London research as well: " I'd like to re-iterate the simple point that unhealthy communities are simply communities in unequal societies. The health of the poor (and the not so poor) is damaged by the inegalitarian distribution of income and other material resources, employment and power. The effects of inequalities can be compounded by impoverished social networks and a lack of hope for the future. Unhealthy communities are, in addition, divided communities in divided societies. Their members lack opportunity or may be diverted from developing ideas and recognising shared interests with others. The major division in society does not lie between the very poor and the rest of society: it lies, as Westergaard has recently argued, between the rich and the rest, (Westergaard,1992). Statistical evidence and political analyses suggest that both wealth and power have become increasingly consolidated and centralised during the last 15 years,"(Cattell 1995, p 17).

I suggested earlier that how people respond to poverty, deprivation and inequality has implications for their health. Two responses identified in *Community, equality and health* were related to the East London research: 1) an internalised response, which corresponded to people with more restricted social networks on the East London estates, and 2) an externalised response, associated with people whose networks corresponded to 'Networks of Solidarity'. High levels of crime on the socially disorganised Cathall suggest that a third can be mentioned here: a deviant response. Merton suggested that when the realisation of 'societal' goals associated with the American dream - of achievement, consumption the good life - are blocked, then some would turn to criminal activities or other deviant means of making good (Merton, 1957) .

These ideas were a development of those sketched out in *Community, equality and health* where I further argued that "a supposition could be that the first [internalised] and third [deviant] of these responses are inward looking. Hopelessness can be the response of those so divided, demoralised, and lacking in alternative values, that they are unable to fight back. Criminal activity can be a

response of those who do fight back, but in an inward looking destructive sense. The attack, as Campbell pointed out (Campbell 1993), is on their own community. They will almost certainly have ' bought' the ethic and promise of 1980s and 1990s individualism. These two responses might be thought of as sharing two characteristics. One concerns the harm which they may do: in the criminal case, to the communities in which they operate, in the hopelessness case to the health of the individual *and* the community. The other concerns the structure of their networks: both are likely to be inward looking, restricted and dense" (Cattell 1995, p 18).

"The externalised, and, I would tentatively suggest , positive response, is in contrast, beneficial to the health of both the individual and the community. The networks of people in 'positive communities' will be more likely to be open and outward looking, with some dense clusters - reflecting tolerance of diversity, reciprocal aid and sense of community - but with loose density overall. The latter will be both a reflection of and a function of the propensity to seek and recognise shared interests with those outside the immediate primary or interest group. Members of these networks will share and develop sets of values which, ideally, would run counter to the extremes of both individualism and collectivism. These values will include tolerance of difference, and a desire for wider co-operation. They may also embrace a utopian element, the most essential feature of which I would suggest, would be adherence to the ideals of equality and wider participation" (Cattell, 1995,p 18).

The East London research has shown that the first and third of these 'community' models sketched here fit the 'Restricted' and 'Solidarity' models of social networks of residents. The research also shows however that the network types, and the values associated with each, can co-exist in one neighbourhood and do so in the two East London estates. There is some evidence for 'communities within communities'. However, the more restricted networks were found more frequently on the socially disorganised Cathall. Yet even on Cathall there were 'Networks of Solidarity', a reflection of opportunities for involvement in initiatives. The research has also shown that residents' patterns of social networks are diverse, that they cover a wider range than those associated with the two extremes of internalised responses/restricted networks, and externalised responses/networks of solidarity indicated here. On Cathall networks were to some extent polarised between the two extremes, but in between them were a range of innovative, individualistic networks, each with their own implications for health. On the more socially organised Keir Hardie however, network patterns were easily identifiable and classifiable. The 'Similar' and 'Traditional' networks reflected social organisation in a traditional working class community.

Social organisation, equality, health and utopian dreams

Overall, this research suggests four things in connection with health research: Firstly, that when the health effects of social networks are examined, it is useful to look at membership groups, and reference groups as well as those elements more traditionally examined such as size. Secondly, that network patterns vary between neighbourhoods, and in this respect, place makes a difference to health over and above the socio-economic characteristics of residents. Thirdly, that an examination of patterns of social networks can be useful for understanding patterns of social inequalities in health. Fourthly, that social networks, attitudes and values, and health and well being are inter-correlated.

How does this research compare to the 'Roseto studies' mentioned in chapter 1? Roseto, a small town in America, displayed consistently lower rates of mortality from coronary heart disease and deaths from all causes than neighbouring, and similar towns in terms of social class. Roseto was a predominantly Italian town, characterised by much higher levels of ethnic and social homogeneity, close family ties, cohesive community relationships and participation in local organisations than neighbouring towns with worse mortality records, (Lasker et al,94). During the 'deadly decade' 1965-74, Roseto lost its mortality advantage. The change co-incided with social change, fewer marriages within the community, and a decline in activity in local clubs and organisations. Some of Roseto's traditional features, as we have seen, were similarly still evident on Keir Hardie, though it has never been a community with high rate of participation. However, the major difference is, that, those who participated in organisations- on both Keir Hardie and Cathall- did so in conditions of heterogeneity. They were tolerant of others and, on the whole, willing to mix with people unlike themselves. Their networks, made up of both similar and dissimilar persons, provided access to a variety of health protecting functions associated with social networks.

One of the dominant themes here has been the health benefits of participation in organisations and initiatives and the values and attitudes of residents who participate. In 'Community equality and health' I tentatively discussed the potential of local communities for fostering certain health promoting values: "The local community *can be* a potential arena for the growth of solidarity and hope, but arguably, their source is not to be found in *either* the local neighbourhood, *or* the identity/interest group, *or* the wider society, but is located in *all three*. Neighbourhoods can foster sociability and a sense of local community, and groups can develop shared interests and forge alliances with others. Democratic and essentially outward linking structures could be seen as essential to the positive synergetic community. Cole's associational ideas may well, as Hirst has suggested have now found their day (Hirst, 1990). We need to think about the possibility and

desirability of creating new structures to support co-operatives, "democratise" participation, to ensure representativeness, and to formalise connectedness with wider decision making formations. Both the structure of the co-operative community networks, and the values which both nurture and grow from them are likely, if these ideas can be sustained, to have a positive impact on health. In addition, these open, outward looking structures , in empowering, carry the potential of making the eventual realisation of re-distributive goals a less distant prospect. A result would be a narrowing of inequalities in health. Moreover, it is not inconceivable that greater democratic input would, in itself, impact not only on national policies, but might, in sparking new ideas, help to inject a little utopianism into the ideologies of political parties now burdened by the New Realism. As Tawney once put it: 'What matters to the health of society is the objective towards which its face is set', (Tawney 1964, p.25)". (Cattell 1995, p19).

These arguments are not disproved by the East London research. I may , however, in promoting the role of participation in this paper, have neglected features of local social organisation which are equally important for the viability of the community. Minkin advocates what TH Huxley described as the slaying of beautiful hypotheses by ugly facts as an important and continuing element of the research process, (Minikin, 1997). The ugly fact was, in this case, that Keir Hardie, contrary to expectations, was more socially cohesive, had more thriving social networks and better health potential than Cathall. The problem lay in the selection of the estates. As well as differing in their opportunities for participation, they are also very different estates in many other respects. The hypothesis in this case, was wounded, but not gravely. Although this research has demonstrated that a strong sense of community is felt by those who participate on Keir Hardie and Cathall, it is also evident in Keir Hardie residents who don't. Participation in organisations is not the sole, or even main source of a attachment to the community for the majority of residents. Those elements of a traditional, stable, and cohesive neighbourhood evidenced on Keir Hardie had many health protecting benefits, mutual aid not least among them. The plentiful availability of local work in the past was the most essential feature which contributed to a strong sense of community and to values of mutual aid. It was also associated with participation in social and sports clubs. The stakeholder vision, where it includes economic inclusion, is appropriate here. Wider social inclusion at the level of the community needs economic inclusion as well.

The importance to health of social cohesion, social capital, and resources, and which I have emphasised here, is confirmed in recent work. An American study suggests, not only that income inequality leads to increased mortality, but that it does so via disinvestment in social capital or declining levels of social cohesion and trust, (Kawachi et al, 1997). Using American General Social

Survey data, Kawachi et al found that income inequality in American States was strongly and negatively correlated with both per capita group membership and with the proportion of people in each state who believed that people could be trusted. Both social trust and group membership were associated with lower rates of mortality.

Wider social inclusion, and cohesion, at both the community and societal level, as suggested earlier, needs a more equitable distribution of resources. As Lord Young put it "Equality and fraternity were never meant to be in conflict" (Young, 1996,p.6). In any case, it is only through re-distribution that we are likely to witness a dramatic reduction in health inequalities. The structural analysis for the Lea Valley left no doubt as to the strong relationship between lower social class, poverty, deprivation and poor health.

The WHOs social model of health identifies positive, subjective health as "a state of physical, mental and social well being and not merely the absence of disease or infirmity", (WHO1978). For Shin and Johnson the quality of life is linked to "the possession of resources necessary to the satisfaction of individual needs, wants and desires, participation in activities enabling personal development and self actualization ..." (Shin and Johnson,1978). A social model of health derived from my research builds on the definition of social cohesion already offered. For health and well being, the socially healthy individual is one who is more likely to be socially included in a community of attachment, (involving interaction with others, a sense of community and identity and solidarity) and whose individual and neighbourhood resources (including jobs) are adequate for needs and for social participation. The individual will be tolerant towards others, will have hope for the future, be committed to equality as an ideal, and her or his social networks will include a wide range of membership groups providing access to the many benefits to health associated with social networks. A utopian model perhaps. The emphasis on equality as a precondition for enhanced community life was a strong strand running through the work of the 'Utopian Socialists'. A vision of Twentieth century London described it as a city peopled by extraordinarily healthy, happy and long lived men and women. It was a London of small communities where all were addressed as "neighbour" and where strangers were welcomed. There was useful non-alienating work for all, goods were made for use and pleasure, not profit, and consumption was low. These were, above all, self governing, co-operative and egalitarian communities, without poverty, and without riches. Central government, once necessary to protect the rich from the poor, had withered away. It was, of course "News from Nowhere" (Morris, 1890). William Morris, in giving expression to his conception of a better society had identified some of the keys, not only to improved health and well being, but to a reduction in patterns of social inequalities in health as well.

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APPENDICES

APPENDIX 3: RESPONSES TO POVERTY AND DEPRIVATION

Responses to poverty and deprivation examined here can be broadly grouped into those which focus on places, and aim to regenerate a deprived area, and those which focus on people, and aim for example to alleviate the poverty of vulnerable groups, or to involve people in the local community. Some policy developments will contain elements of both.

Four areas of policy have been examined in relation to the four boroughs of Tower Hamlets, Hackney, Newham and Waltham Forest: urban policy; anti poverty and community development work; housing initiatives; and environmental initiatives. The aim is to identify and consider a few local examples, and not to provide a totally comprehensive coverage, nor to make comparisons between boroughs.

Urban Policy

A number of initiatives were targeted at deprived areas during the 1980s and 1990s."Objective 2" is one of the latest of a series of such initiatives aimed at regenerating defined areas by tackling economic decline and high unemployment. In January 1994 the European Commission designated The Lea Valley area as eligible for support under objective 2 of the Regulations governing the European Structural Funds. The eligible area covers parts of 6 London boroughs; Enfield, Waltham Forest, Haringey, Hackney, Tower Hamlets and Newham.[1] Previous initiatives have included, over time, City Challenge, the Urban Programme, Housing Action Trusts, Government Task Forces, Assisted Area status, the Single Regeneration Budget, Training and Enterprise Councils, and City and Derelict Land Grant.

Government regeneration strategies have tended to focus on places rather than people. They are characterised by an emphasis on economic objectives, by competitive bidding, and by expectations that local authorities enter into partnerships. At the same time, Government appointed bodies, including the Docklands Development Corporation, were granted certain powers over and above those exercised by local authorities.[2]

Initiatives have been criticised on a number of grounds. An Audit Commission report, for example, pointed to the complexity and idiosyncrasy of government support programmes,[3] while the Government commissioned Robson report highlighted the few opportunities available for local authority and local community involvement in regeneration.[4] Both stress the need for more effective coalitions of agencies involved. Other critiques have focused on democracy; community development; and the economy.

Some commentators are unhappy with the "top down" element evident in some schemes, and with what they consider to be an uneven balance of power in partnership arrangements. The pendulum needs to swing back, argues Thompson for example, from being purely on the side of the developers, as it was in Docklands, back to a more meaningful level of partnership. [5] A number of Community Development practitioners and commentators are suspicious of what they see as anti-democratic tendencies of the partnership approach. For example "We need to challenge bland concepts of partnership which deny recognition of conflicts of interest between grand capital schemes and local residents, and we need to challenge 'communitarian' ideas which seem to promote community leaders into the role of repressive moral guardians. ' The emphasis is on the promotion of channels which can give a direct role and voice to community groups in regeneration policies and programmes, rather than leaving this to professional experts. [6] Beresford has argued that the new local arrangements of trusts, quangos and the quasi market offer less control and accountability to local citizens than the old democratic system. For Beresford the key questions are:

whose democracy? Whose empowerment? A reduction in the influence of local government is a cause for concern. There are fears that it is being replaced hy a complex network in which systems of managerial accountability are weaker than in local government.[7]

Some Community development workers are concerned that current initiatives, particularly the Single Regeneration Budget, failed to provide resources for people centred community work. (Standing Conference ,1994, *An Approach to democracy and empowerment).* Their concern reflects Community Development philosophy. The SCCD Charter focuses on people, and covers issues of empowerment, social change, sharing and development of power, skills and experience, and enabling structures. It is concerned with both neighbourhoods and communities of interest[8]. Networking is the basic tenet of SCCD, it creates and supports opportunities for coalitions of national organisations , encourages forums of interest and networks.

Partnerships are seen as potentially positive where they are the outcome of sustained community development work combined with political action: "Community development aims to empower disadvantaged individuals and groups and foster political action. Solidarity is an expected consequence, seen in the emergence of coalitions covering a greater variety of interests." [9]

From an economic perspective, urban regeneration programmes have been criticised on the grounds that local people have not benefitted. [10] Two Policy Studies Institute reports assessed the effects of initiatives targeted at "deprived areas" during the 1980s. [11] Whilst acknowledging that without the various initiatives the gap between conditions and opportunities in deprived areas and other kinds of place might have widened still further, Willmott nevertheless concluded that Government urban policies over a decade had only very limited success in reducing disadvantage. The Lea Valley chapter in this thesis demonstrated the extent to which poverty, deprivation and unemployment are dominant features in the four local boroughs designated as deprived and therefore included in his analysis - Tower Hamlets, Hackney, Newham, and Haringey.

London's Other River looked at data and evidence on local economies and discussed the impact of economic regeneration in the Lea Valley region. It suggested that good local jobs, for example, were not going to local residents. It was concluded in addition, that:

'These findings on the Lea Valley confirm work conducted elsewhere. Of the 20,000 jobs that came to Docklands between 1981 and 1987 for example, as many as 75% were taken by residents of areas outside the three Docklands boroughs of Tower Hamlets, Newham and Southwark.[12] They are also illustrative of Massey and Allen's research in Cambridge who concluded that "rich places" associated with growth, can also be places categorized by growth in low waged service jobs. Growth and poverty were seen as interdependent, an echo of Massey's earlier analysis of the London Docklands development. Highly skilled and well paid jobs were designated for outsiders; low skilled, low paid jobs went to locals, with inevitable consequences in loss of income and deskilling.[10] Moreover, although there has certainly been real growth in jobs in newspaper printing, retailing, banking, finance and insurance in Docklands, this has, to some extent, been offset by loss of jobs in other sectors.[13]

'Analysts in some boroughs have pointed to a mismatch between local job opportunities and the skills (or lack of them) held by local residents, and it is sometimes assumed that lack of skills in general is a cause of unemployment. Political parties have tended to promote education and training as a universal panacea for Britain's economic ills. Yet it is not easy to identify the kind of training which would help Lea Valley residents to gain employment. Many skilled workers, for example, are out of work in the area. And even if we got the training right, would the jobs - for locals- necessarily follow? It is not clear that they would without intervention, and of the right sort.

Anecdotal evidence suggests that support services for the business sector, which provide the kind of jobs which local people can do, are currently being relocated out of the fringe City areas of Hackney and Tower Hamlets. If firms like these could be encouraged to stay, then local training programmes directed at work in this expanding sector would have purpose. Local training schemes, like those being provided by central government initiatives such as HATs and City Challenge in several of the Lea Valley boroughs, are only likely to have a short term ameliorative impact on unemployment unless they can be followed by real, that is, reasonably long lasting, jobs. The need for locally designed and appropriate regeneration initiatives is clear. In particular, there may be an argument for more clout on the part of local government in interventions like the new Royal Docks initiative, particularly in so far as they were able to ensure a higher proportion of jobs going to local residents.

'Given the generally perceived deficiencies on the part of large scale initiatives in their ability to affect a trickling down of opportunities to poor residents, it is becoming increasingly apparent that a shift in attention to the small scale may be more appropriate. Contributors to a recent conference on regeneration strategies for North and East London organized by a number of London boroughs including five of those in the Lea Valley, argued that the mega development may not be the best approach. The more difficult but longer solution they believed, lay in the encouragement of small businesses with sustainable technologies in diverse sectors. Similarly, improved help and advice to local firms, particularly to small businesses has been advocated by Keep and Mayhew, and small businesses - which dominate the economy of much of the Lea Valley - are expected to be the biggest generators of jobs nationally.[14] Yet small local start-ups (which do tend to employ local people) have a poor survival record, and are clearly in need of sustained help.

'Regeneration - at least of the large scale economic kind- appears to have done little to halt their diminishing prospects and living standards. Some local boroughs have the worst , or are amongst districts with the worst scores in England on a range of individual and composite deprivation indicators, (Cattell, 1997)

Voluntary sector and Community Development initiatives

As Willmott points out, initiatives in deprived areas are not the monopoly of central government, but involve Local authorities, the private sector, and the churches as well. [15] Local councils in East London, if Newham is typical, appear positive about the present collaborative arrangements, and see in them signs of hope for Newham residents, even in the present climate of limited resources and cuts. Newham Council's *Shaping the future of Newham - into the 21st century* begins... "Newham is on the verge of a radically different future - with far better prospects for local people and businesses and on the basis of a common vision and shared commitment to change in a spirit of partnership and co-operation"[16].

Compared to the large scale and well funded area development already discussed, most of the project examples undertaken by the Voluntary sector and by Community development workers are very small fry indeed. Some examples are identified here for the boroughs of Newham and Waltham Forest.

In each borough there is an umbrella group for the voluntary sector. In Newham, "The Aston Community Involvement Unit equips and informs the people of Newham ,to enable them to work together to effectively tackle issues of poverty, deprivation, racism, disadvantage and powerlessness" [17]. A parallel organisation is Voluntary Action Waltham Forest. It aims to co-ordinate and promote the common interests of voluntary and community groups ; influence decision making in the Local Authority, health service and other agencies; strengthen the voluntary

and community sector by encouraging networking, information sharing and good practice in service delivery; ensure equal access to all available resources and to give particular support to disadvantaged groups; and enhance the effectiveness of the voluntary and community sector. [18]

The Aston CIU have identified Key tasks for the voluntary sector: identifying groups and neighbourhoods which are particularly hard hit by poverty and unemployment. They advocate a combination of greater provision, greater participation, and more welfare rights work. They see a need to focus on children, ethnic minorities, and the elderly.

Commenting on the relative youth of Newham's population, the CIU suggests that key areas for voluntary groups to concentrate their efforts on should include the provision of more parent and toddler groups, play groups and nurseries and youth facilities. They recognise a need for greater inclusion of ethnic minorities in voluntary sector activities, both as participants in the traditional "white led" groups but also in a stronger and well resourced "black led" voluntary sector. The CIU recognise that fragmentation will need to be avoided however, and conflicts over the allocation of scarce resources between ethnic groups dealt with. They believe that conflicts could be minimised and more easily resolved by the growth of networks of goodwill, based around a common struggle for social justice for Newham as a whole"[19].

Because most Newham pensioners have only the basic state pension plus means tested benefits, and may be living in accommodation which is in poor repair, active welfare rights projects are advocated, as are home insulation and repair schemes. A key role for the voluntary sector it is suggested, lies in organising social activities, visiting schemes and emergency alarms to tackle the effects of loneliness amongst increasing numbers of pensioners living alone,

The Community Involvement Unit has been involved with a number of recent poverty alleviation initiatives. The East London Churches Homelessness and Housing alliance enables homeless people to move out of hostel accommodation. The Newham Organisation for Stopping Hunger (NOSH)provides a Sunday lunch club with very cheap meals. Customers included elderly people living alone, single parent families, young unemployed single people, homeless people, refugees, those with learning difficulties and some with mental health problems. In 1993 CIU helped the Fraud centre to run a welfare rights course for voluntary advice workers. The key poverty alleviation project for 1994, in association with a retailer's and Forest Gate Methodist Church was a Baby Equipment bank. Supplies of baby equipment gathered by charitable donation from people in affluent areas and /or large suppliers were provided at no more than half the second hand market price. Customers were to be those parents on benefit. [20]

The documents examined above suggest that the voluntary sector is keenly aware of groups which need help, and action which needs to be taken, but are hampered by a lack of resources. Respondents interviewed later, reported for example, of cut backs in youth work on the part of Newham Council.

A collaborative project in South Canning Town combines features of area regeneration with people centred community development work .The Canning town and Custom House Renewal project is described in the chapter on the Keir Hardie estate.

For Voluntary Action Waltham Forest, the focus has been on building partnerships within the voluntary and community sector through work such as the Action Against [Community care] Charges campaign, Community care Forum, the African Caribbean Forum, as well as developing relationships with the local and health authorities, WF Housing Action Trust, London East Training and Enterprise Council. The Voluntary Sector forum provides an opportunity for local groups to

discuss issues directly with elected councillors. The group co-ordinates and supports Forums, in conjunction with the local authority, on vocational training, service users, the voluntary sector, and community care. Leaflets on these forums emphasise partnership, networks, and information exchange.

Despite an apparently wide range of voluntary sector activity in WF, the sector is reportedly under threat and cuts are planned. Newham and Hackney are said to receive a much larger amount of funding. Fewer groups are funded in the borough compared to other local boroughs the grant aided process is difficult to access.. Voluntary Action Waltham Forest deals with a large number of groups who are not funded.[21]

Local Authority Anti Poverty strategies

Several boroughs in the Lea Valley area have anti-poverty initiatives in place, and some have active community development projects and other initiatives aimed at involving and empowering local people. Some of these are council led, some involve organisations like Bootstrap and Priority Estates Projects working on deprived estates, and some involve partnerships between councils, voluntary organisations, or other relevant bodies, including Health Authorities and businesses. The brainchild of Lord Young, an exciting project, Tower Hamlets Summer University, was set up last year to help broaden the horizons of local youngsters.

Anti Poverty strategies, it has been suggested, are interpreted in different ways by different councils. For some, anti-poverty is concerned with welfare rights and take up campaigns, for others, the focus is on a grass roots, community development approach. Community action is a traditional way of tackling poverty in many parts of the UK, particularly in inner city communities. Wheeler argues however that if we are to tackle poverty and inequality effectively, then a strategic direction is required which goes well beyond both community development and income maximisation. She advocates an approach which would involve councils looking at the whole distributional pattern of local government spending. In some authorities, that is what an anti-poverty strategy means. Yet others are developing this strategic direction with reference to "social justice" or regeneration.[22]

The approach in Waltham Forest Council, as in the voluntary sector, places emphasis on forums to achieve anti poverty objectives. In this case, forums involve representatives from different council departments. The anti-poverty forum began its work in September 1993, replacing the department's debt forum meetings which had concentrated solely on debt related policy matters. As well as debt, the new forum addresses homelessness, welfare benefits, quality of life, equality, information, consumer rights and environmental health. The forum works to identify changes that other departments can make in their policies that will promote the Authority's Anti-Poverty strategy, and minimise the effects of poverty on local residents. The results have been a greater awareness of local poverty issues amongst officers from different departments. [23] Forum documents would suggest that WF seem to be going some way towards a holistic approach to tackling poverty and deprivation.

Progress has been made on advice and take up aspects of anti-poverty work, including ascertaining the information and advice needs of the borough, targeting areas of the borough where there is no existing advice provision; redirecting advice budgets if necessary to higher priority areas; consulting and liaising with the voluntary sector, looking to find private sector funding for advice centres, targeting and or monitoring advice services to disabled people, black and ethnic minorities, and women who are carers. Success was evident in the Disability living allowance take up campaign - the campaign succeeded in generating extra income (in the form of unclaimed benefits)for

disabled people in the borough .Success was also evident in a reduction in the number of Income Support claimants facing bailiff action for council tax arrears. Future work, and forum meetings, will concentrate on fuel debt, monitoring of the Child Support Act, and changes to homelessness legislation.

Housing initiatives

Relatively large scale, targeted housing initiatives in Hackney and Waltham Forest combine regeneration of the physical environment with the development of opportunities for residents. The first, the Community Estates Initiative in Hackney, is Council led in partnership with others, the second, Waltham Forest's Housing Action Trust, is a central government initiative in partnership with others.

Hackney Council's Comprehensive Estates Initiative (CEI), aimed at regenerating some of Hackney's more deprived local estates. It was launched in 1991 to transform life on 5 major system built Hackney estates - Clapton Park, Holly St., Nightingale, New Kingshold and Trowbridge - by tackling a range of housing, social, community and economic problems. The CEI is a partnership between the council, the private sector, housing associations, voluntary organisations and residents. The Housing Corporation, Hackney Task Force, Dalston City Partnership, the police, Health Authority and various training agencies are also contributing to the development of the estates. [24]

Some were unpopular and highly stigmatized estates, linked with bad housing, crime and vandalism, and those where community morale was low. Hill has described them as places "where collectivist dreams turned to municipal nightmares." [25] Housing problems before redevelopment included system built blocks, internal access corridors, infestation, condensation, poor insulation, structural problems, and squatting. When tenants were decanted at the beginning of development, few wanted to return to many of the estates. By 1994 a majority expressed a desire to return to their re-developed estate. Perceptions of the area as stigmatized on the part of outsiders however may take longer to change. A resident of Leyton, commenting on the demolition of CEI estate blocks said: "You can blow it up, but its still Hackney".

It is intended that the regeneration initiative will benefit all the communities living on the estates by providing them with better housing, better facilities and better opportunities. The CEI has provided opportunities for resident participation, employment and training. Empowering people to have more control over decisions that affect their lives is one of Hackney Council's core values. It is facilitated here through communication and through participation in decision making. All estates have Estate Development Committees (EDCs). EDCs have a broad representation of tenants and local councillors and meetings are attended by staff from the local housing office and technical services. Tenant control takes a different form on each estate.

The CEI aimed to employ local labour on construction contracts. Training and employment programmes provide a variety of courses from learning languages, literacy and numeracy, to child care and community business. The Hackney Employment Link project (HELP) works on New Kingshold and Trowbridge, aiding residents in preparation for work. Specialist advice and sources of training are also available for people with disabilities, the long term unemployed and ex-offenders. The voluntary agency, Bootstrap, has been providing job counseling and advice on Clapton Park, Nightingale and Holly St. There do appear to have been successes, if modest. Of those who received job counseling on Clapton Park and Nightingale, *and kept in touch with the agency*: 13% went on to get a job, and 21% enrolled on training course. Of those attending training courses - 63% went on to further training, but only 4% got jobs.

Press comment on the CEI has been very favourable, especially on the extension of tenant power. Writing on the Clapton Park development, Hill interviewed the chair of the Estate Development Committee, for whom 'The EDC is the voice of the people, it is all about trying to get back some community spirit.' An encouraging transformation he notes on Clapton Park stems from consulting tenants on design changes. In particular, this has a positive effect on the behaviour of disruptive tenants.[26]

Barriers to success, inevitably, concern funding problems. Although the EDC fought for and obtained the money for a nursery on Clapton Park, education cuts have meant there is presently insufficient money to staff it properly.

Waltham Forest Housing Action Trust (HAT) is a non-departmental public body formally designated by the Secretary of state in December 1991. The approach is on targeted regeneration. The HAT covers four large, geographically separated high rise estates, including Cathall which was selected as a case study area for this research. The HAT's primary task is to provide new homes for all existing tenants over a period of 8-10 years at an estimated total cost of £250 million. Like other regeneration schemes, the HAT includes wider economic and social responsibilities as part of its overall mission, but sees an advantage of their programme over others in that by targeting programmes and resources at 4 relatively small, fixed communities (6,400 overall pop) over a concentrated period of time, they will be more able to reach those parts of the community other programmes often fail to reach. From a community development perspective, the HAT believe that they " can jump on the bandwagon of people's excitement. The prospect of a brand new home ..[enthuses people and] makes people willing to try things, to have a go".[27]

Major partners include the Local Authority [which I later discovered from local MPs were instrumental in helping tenants to have their estates re-development as a HAT], and the employment Service, the local TEC, the Health Authority and the FHSA.

The HATs mission statement involves "working with tenants to develop homes, people and communities which will bring about long-lasting improvement in the quality of life" Their priorities are to tackle unemployment levels, low skill levels, poor health and social exclusion. Tenant choice and participation is part of the philosophy, as is the creation of stable, confident communities. The HAT appears to be popular with residents :fewer tenants moved off the estates than expected and a customer satisfaction survey conducted in March 95 showed that 82% were satisfied with HAT services. The HAT claim that up to 1000 participate in activities across the four estates, but would like more involvement, particular amongst younger, unemployed people.(My subsequent research on a HAT estate suggests that these figures exaggerate the true level of participation). Estates with the highest levels of participation appear to be those which already had voluntary and community development activities in place before the HAT took over.

The HAT runs a Career Advice and Placement Project offering guidance on education, training and employment . It is claimed that this service has helped 327 residents into jobs and another 301 residents into training. It is not clear however how many of these jobs will be secure or short term. They are working with the Adult Literacy and Basic Skills Unit to improve courses in ESL, and the Trinity Business Skills centre which provides training in business administration and information technology. 53% of their people on full-time courses went on to further training or jobs . It is not

clear what proportion were actual jobs.[1] Jobs do appear to be available for locals on the construction sites. Langthorne Construction Skills training centre seems to have been more successful in placing trainees in jobs - in 94-95 53% of trainees found jobs with site contractors. From a total of 51 residents who finished training courses at Langthorne, 38 went on to find jobs on our redevelopment sites or somewhere else. Business initiatives include a scheme on Cathall Rd Estate to provide low cost workshop space.

It is difficult to judge the extent to which some of the activities are new, or would have been in operation without the intervention of the HAT. Anecdotal evidence from council employees suggests that ESL classes for example, were simply duplicating those already established and available and provided by the Local Authority.

Part of the community development programme is to help provide more childcare. The estates' population is very young, with some 40% aged under 11. The HAT is supporting the development childminding networks, providing places in LBWF nurseries for tenants on HAT training courses, supporting estate based playgroups and creches, providing training in childcare skills and establishing new After School Play care schemes on Boundary and Oliver close estates.. I discovered later that some of these were already well established on the Cathall estate before the HAT. Other estates within the HAT's remit may have been less well provided in the past however.

Only a minority of estates in Waltham Forest are HAT estates. Local authority housing philosophy appears similar to that of the HAT, but the resources they have at their disposal differ significantly from those available to the HAT . The Local Authority Housing Strategy statement places a great deal of emphasis on consultation, with local groups for the disabled for example, with housing associations, with private landlords, and it emphasises the need for partnership and competition. Referring to tenant participation on the HAT estates they see a challenge for the Authority in replicating that experience across the rest of its housing stock. [28]

According to one respondent, interviewed as part of reputation of area interviews- there is concern about estates which are missing out. One such estate, Avenue estate, is near to the Cathall HAT estate. Avenue were part of the Estates Action Programme, but the funding was cut half way through. An official reported: "We were left with an estate half done. Lots of work went into setting up a tenants organisation, , but when the funding was cut, it was impossible to retain the momentum."

The Federation of WF Tenants supports council tenants groups and helps with individual tenant problems. Their annual report makes a plea for tenants to support the Federation "as the only borough wide organisation run by tenants for tenants." [29] The Federation would like to involve more black and ethnic minorities in the tenants' movement as well as more young people. In the 1980s the Federation argued for more council housing to be built, but the council's role, they point out, has been taken over by housing associations, which can only provide much needed rented accommodation on a small scale, whilst council housing waiting and transfer lists are still bulging

The Federation Secretary believes that Tenants associations and community centres are particularly important because they can help to foster a sense of community. Work is going on in some estates to increase involvement in community centres; one tenants association has been successful in getting a room at the base of a tower to use as a much needed youth club, and there

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[1]The total number going into jobs was 27, out of a total of around 156 training places. Thus c.17% found paid employment.

is a tenants campaign to prevent the loss of a children's kick about area on another estate.(Tenants' Voice February 1994). I get the impression from Federation Newsletters and conversation with Federation's Secretsry that this all operates on a shoestring. The resources available to the Federation and the TAs stand in marked contrast to the resources available to tenants steering groupsfor example on HAT estates.

PEP

The HAT and the CEI have had the benefit of knowledge gained on sustained work on estates by the Priority Estates Project(PEP). PEP is sponsored by the Department of the Environment and works with local authorities and tenants to improve services on some of Britain's most unpopular and stigmatised estates, including several in Lea valley boroughs.

There were four key elements to the approach to estate problems develop by PEP during the 1980s: locally based management offices and the attraction of other services to estate level; tenant and resident involvement, with detailed consultation at all stages of development; co-operation between central and local government and high level political commitment to change and experiment; an outside catalyst and a supportive community facilitator.

Describing the project's impact on an estate in Wales, Power described how tenant involvement was not simply a localised, parochial affair : "A crucial element was the link between estate residents and the outside world, the local services and the wider urban area, the local offices and local customers...Tenants went all over Britain to conferences...they were put in touch with businesses, credit unions and co-ops...on the estate, networks of support and mutual aid were constantly forming and re-forming"[30].

A long term study of twenty of the most unpopular and marginalised council estates in the country concludes that "they were restored from extreme social, physical and management problems through continuous, locally based, intensive, hands on management and tenant involvement". Half of the estates were in London boroughs, the rest in other major cities with declining populations. The study looked at these estates between 1980 and 1995 and found that by the end of the study period, residents on most estates believed that conditions had improved even though, by many measures, the communities were far more disadvantaged. Residents involvement was seen as intrinsic to the success, but residents' representatives needed support and training also. [31] The authors conclude that conditions can improve with targeted resources, even when the population remains poor. In order to maintain conditions, however, such estates need strong and consistent support through staff with hands on management control in permanent estate-based offices. This is important for when HATs pull out. For tenant involvement to be sustainable, ongoing support will be necessary.

PEP Estates in the Four boroughs

Questionnaires to PEP workers with experience of East London estates reported on estates in East London. These were :

Newham: Carpenters estate is a mixture of some 650 high and low rise properties. Many of the terraced houses have been sold. The PEP officers' comments would suggest that Carpenters is a fairly traditional community.

Local associations include a recently formed playgroup; carpenters Tenants and residents association; an informal estate forum involving all groups on the estate and workers from statutory and non statutory bodies and a developing tenant management organisation. PEP helped reform the

tenants and residents association. The association helps to bring the community together through an annual fun day. PEP has been involved since c. 1992 and the respondent to the questionnaire has been a consultant to the development Committee since 1994.

Hackney: Clapton Park Estate is one of the estates benefitting from Hackney's comprehensive Estates Initiative .It consists of three estates; Clapton Park, Millfields and Nye Bevan. All but one of the original tower blocks have been demolished. The main square, Gilpin Square has been refurbished as have a number of the adjacent medium rise blocks. The estate has a poor reputation. It was seen as "riot" material in early 80s, for the usual reasons - unemployed youth, poor relations with police. Change has taken place over last 10-15yrs due to a series of community initiatives eg Hackney Youth in Action which set up an advice shop, youth club and play project. Local associations include the Clapton Park Tenants Association; Nye Bevan Tenants Association; Hackney Youth in action (becoming a community trust); Clapton Park tenant Management association; The Pedro Youth club; and the Estate Development Committee which oversees the comprehensive estate initiative. The PEP's main role has been to develop and support the tenant management organisation and thus improve housing services on the estate. Local staff are now more responsive and better able to deliver. At least one person has secured a housing job as a result of his involvement and attendance on a PEP training course. PEP has been involved on this estate since 1988. The Respondent has been involved since October 92 as a PEP consultant advising and supporting the developing Tenant Management Organisation.

Tower Hamlets: The Longnor, Norfolk and Osier estates, which together are managed form one estate Base in Norfolk estate, are in good repair generally and well managed. A satisfaction survey in 1983 showed a good level of resident satisfaction. Norfolk estate T.A has 7 or 8 active members but numbers have been falling recently- particularly after 'the local elections swept the Liberals out and brought in Labour with a quite different approach to local participation.' The Langnor estate TA has effectively collapsed though some of the friendship networks that kept it going still exist. One of the reasons for the recent decline in T.A activity has been that a no of the activists were members of the Liberal party. The election defeat punctured their confidence and they feel excluded from local political (eg tenants forum) activity now.

The PEP officer reported that "Sadly the work of the PEP initiative came to nought. Although a survey demonstrated support for tenant management, there was in practice insufficient active support, and in the end the project was obliged to close down. I suspect that there were interpersonal dynamics - dislikes etc - that may have lain behind or below the surface, which we never managed to get to . at all events, I think we may have had very little impact in the end....In general, there were relatively high levels of satisfaction among residents with the services they receive. Only the most active were aware of the possible consequences of CCT in housing management. When they themselves became discouraged, it was all over really". The respondent was involved as a consultant to the tenants group for almost three years in all - through 'promotion' "feasibility" and part of the "development" phase.

Environmental initiatives

Waltham Forest Council has instigated an Area Improvement Initiative. Area Improvement teams operate in a neighbourhood and seek to make a rapid and major improvement to the environment and provide opportunities for the involvement of the local community. In selected areas, the team has been encouraging the use of poop scoops;undertaking rapid area clean ups; planting street trees; removing clutter form the pavements; designing shrub beds; improving school grounds; taking up residents concerns; conducting neighbourhood walkabouts; holding window box competitions; making free trees available to residents living in these areas. In the South Leytonstone area

initiative, additional projects included repaving, making new and safer pedestrian crossings, repairing street furniture, lighting and signs. Regular public meetings are arranged so that residents can have their say.[32]

The team do neighbourhood walkabouts, when they ask people to tell them about everything they like about their area and everything they don't. An initiative officer reports: "We work intensely in small areas, and get a list of priorities from neighbourhood walkabouts. We act as advocates in a sense. We can flag up issues, but cant necessarily get funding though. We have tried to design out crime - we remove big shrubs which cast shadows, and plant bulbs and trees instead."

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APPENDIX 4: DEPTH SEMI STRUCTURED INTERVIEW SCHEDULE

INTRODUCTION

I'm exploring ways in which peoples changing life circumstances and experiences might affect their health and attitudes to life. I'm particularly interested in peoples social networks, - systems of relationships of family, friends, neighbours, colleagues, acquaintances

For this stage of my work, I'm conducting a small scale community study, in two separate areas of North East London. I want to talk to you, as a resident about

a) your **knowledge** about your **local area**, so that I can learn from your expertise

b) yourself, your own **social networks**, your **attitudes** and values, and a little about your own **life history** and **health history**.

1)LIVING IN THIS NEIGHBOURHOOD

a) How **long** have you lived round here? Why did you **move** here?

b) **What is it like**?

c)How far is there a **sense of community?**

Are there places where people can meet socially , eg shops, clubs schools

d) What are the **people like** round here? Are they **friendly** , do they **help** each other? is it easy to **get to know** people. What are the **neighbours** like

e)Are people round here **joiners?**

g)Where did you **live before** you moved here? How do the two places compare?

h) Can you generalise about peoples health?

2)SOCIAL NETWORKS/ PEOPLE YOU MIX WITH, HAVE CONTACT WITH

(I'm Interested in family, friends and neighbours , (informal relationships) as well as formal relationships- fellow members of organisations, colleagues, people who you or members of your family receive services from.

I'm interested in who you see, have contact with, why you see them and where you see them, where they live I will not interview anyone whose name you mention)

a) Could you tell me about **yesterday**, what did you do, who did you see or talk to?

b) Tell me about the people you've mentioned. What do you see them about, where do you see them, who else was there, where did you first meet, how much time did you spend with them, when was the last time you saw them?

c) How far was this a **typical day**? What would you do, who would you see, on a more typical day?

d) Could you tell me about the people who are **important** to you in you r life? (Thee might include people we haven't talked about, or those we already have)

what about friends?

e)Could you tell me about any of the people you've mentioned (excluding family) who

know each other? How did they come to know each other?

f)Would you say that you tend to mix with people mainly **like yourself**? To what

extent do you mix with different kinds of people?
are there some people you prefer to keep your **distance** from?

g) Out of the people we've been talking about, which are the ones you get on best with?

h) Are there sometimes difficulties with any of the people you have mentioned. do any of them **disagree** with you about things which are important to you .

3)ACTIVITY
Are there any groups you are involved in round here?

Tell me about your **involvement in.....** Has your **life changed** in any way since you became involved?
What do you **get out** of it?
Have you **always** been as **active** as you are now (or more than now)

4)SUPPORT.
In an **emergency,** who would you go to for help?
Eg if you were ill
the children were ill, or you needed someone to look after them
or you were short of money
or anything else

Emotional support. What about if you needed to talk to someone about a really personal matter or needed a shoulder to cry on

Have you received support of any kind recently?

Can I ask you about it the other way round?.
Have you **given support** recently, to whom?
how do you **feel** about this?

5) ATTITUDES, IDEAS AND VALUES

a)Do you think that Britain is a **fair society?**

b)Do you think that things can be **changed** for the better? In what way? **How**?
Do you think that **you** can do anything to change things?
Have you **always felt** like that?

c) could you describe the kind of **Britain** you would like to see in the **future**

d)Do you feel in **control** of your life? (if not, who is)

e) What do you think are the main **groups** in society. (How are we divided up)where would you place yourself?)

e)Do you usually **vote** in general and local elections? Have you decided how you'll vote in the next one?

6) MAKING ENDS MEET

a) To what extent do you find it possible to **manage** on your income?
Do you or your family sometimes have to go without things
how about paying bills, or finding the rent?

b) Have there been time in your life when you found it easier or more difficult to manage?

7)HEALTH

a)How would you describe your health. Is it **better, worse** or about **average** for someone of your age?
has your general health **always** been the same as it I now? How about when you were **more/less active. Has poor health ever prevented you from doing things?**

b)During the last **12 months** has your **health changed** at all?
Have you consulted a **GP**, nurse, Hospital consultant or other medical practitioner etc How often

c) Apart from health, have there been any other major **changes in your life** over the last year or two?

8)LIFE HISTORY, AND HEALTH

a)could you tell me about some of the **places** you've lived in the past. Where were you **born** , who did you live with , why did you move etc

Were there any times when you felt **isolated?** can you describe a time when you had lots of contact with people?)

b) Could you tell me about some of the **jobs** you've had?

c)Looking back over your **life as a whole** can you think of a time, or times when life was particularly **good?**
.....and a time when life was **not so good?**

b)Looking back over your **life**, have there been any periods when your **health** was

particularly **good**? (what were you doing etc)
....and when your **health** was **not so good**?

c)Do you think that **life experiences, the circumstance we find ourselves in,** affects our **health**?
what about people and **social networks** of family, friends, neighbours?

V.Cattell